

Employer-Based  
Family Planning Projects  
Past Guidance and Future Implications

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This report is part of a series of PROFIT Research Studies, which address various topics related to private sector family planning. The studies grow out of PROFIT subprojects within the following three strategic areas:

- # Innovative Investments
- # Private Health Care Providers
- # Employer-Provided Services

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reporting and dissemination of the lessons and experiences of  
the PROFIT Project's work to involve the commercial sector  
in developing country family planning services.

## ***ABSTRACT***

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The U.S. Agency for International Development (USAID) has sought over the past decade to initiate and expand employer-based programs for delivering family planning services in selected countries. USAID initiatives have involved five basic intervention strategies, ranging from direct support (i.e., providing direct assistance and subsidies to employers) to indirect support (i.e., working through business and professional associations). This experience does not provide enough evidence to draw conclusions about which approaches are most effective for achieving key objectives of donors in this area, such as increasing contraceptive prevalence, averting births, reducing public expenditures, improving the method mix, or reaching underserved populations, among others. However, recent lessons suggest that future programs should focus on several key goals, including minimizing direct financial subsidies, providing adequate and appropriate technical assistance, working through umbrella business organizations, and investing in long-term follow-up.

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# ACRONYMS

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AAR	African Air Rescue (Kenya)
AIOE	All India Organization of Employers
ARI	Acute respiratory infection
AVSC	Access to Voluntary and Safe Contraception International
BAT	British American Tobacco (Zimbabwe)
BCJ	Blue Cross of Jamaica
BGO	Benguet Gold Operations (Philippines)
BKKBN	Indonesian National Family Planning Coordinating Board
CA	Cooperating agency
CBD	Community-based distribution
CFU	Commercial Farmers' Union (Zimbabwe)
CII	Confederation of Indian Industry
CIMAS	Commercial and Industrial Medical Aid Society (Zimbabwe)
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
DHS	Demographic and Health Survey
DOLE	Department of Labor and Employment
FEMAP	Federacion Mexicana de Asociaciones Privadas de Salud y Desarrollo (Mexico)
FP	Family planning
FPIA	Family Planning International Assistance (Indonesia)
FPOP	Family Planning Association of the Philippines
GE	General Electric
GHMSI	Group Hospitalization and Medical Services, Inc. (Washington, DC)
HMO	Health maintenance organization
ICC	Indian Chamber of Commerce (Calcutta)
IEC	Information, education, and communication
IUD	Intrauterine device
LCHP	Low cost health care plan
JIEP	Jakarta Industrial Estate Pulogadung (Indonesia)
JSI	John Snow International
KAP	Knowledge, attitudes, and practices
MAS	Medical aid society
MCH	Maternal and child health
MICC	Matling Industrial and Commercial Corporation (Philippines)

MIS	Management information systems
MSW	Mawana Sugar Works (India)
MWRA	Married women of reproductive age

NGO	Nongovernmental organization
Ob/Gyn	Obstetrician/gynecologist; obstetrical/gynecological
PCF	Population Center Foundation
PCPD	Philippine Center for Population and Development
PhilamCare	PhilamCare Health Systems, Inc. (Philippines)
PMAP	Personnel Management Association of the Philippines
PROFIT	Promoting Financial Investments and Transfers Project (USAID-funded)
PSS	Parivar Seva Santha (Indian FP Organization and MSI affiliate)
RH	Reproductive health
RP	Responsible parenthood
SEATS	Family Planning Service Expansion and Technical Support II Project (USAID-funded)
SIEL	Mawana Sugar Works/Shriram Industrial Enterprises Limited (India)
SIFPSA	State Innovations in Family Planning and Services Agency (India)
SMC	Superior Medical Center (Ghana)
SOMARC	Contraceptive Social Marketing III Project (USAID-funded)
STD	Sexually transmitted disease
TIPPS	Technical Information on Population in the Private Sector Project (USAID-funded)
UNFPA	United Nations Population Fund
UNIMED	Brazilian HMO and Physicians Cooperative
UP	Indian state of Uttar Pradesh
UPIEMA	Uttar Pradesh Industrial Estate Manufacturers Association, India
USAID	United States Agency for International Development (mission)
YBK	Yayasan Bakti Kencana (Indonesia), MSI affiliate
YKB	Yayasan Kusuma Buana (Indonesia)
YKM	Yayasan Kencana Mandiri (Indonesia)
ZNFPC	Zimbabwe National Family Planning Council

## ***EXECUTIVE SUMMARY***

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The Promoting Financial Investments and Transfers (PROFIT) project is funded by the United States Agency for International Development's (USAID) Office of Population to encourage and finance sustainable commercial family planning activities throughout the developing world. Some of PROFIT's initiatives are designed to stimulate employer-based family planning service delivery. Two earlier projects, the Enterprise Project and the Technical Information on Population for the Private Sector (TIPPS) Project, also engaged in these kinds of activities. This paper reviews past experience with employer-based initiatives, identifying strategies used and assessing their effectiveness in motivating employer participation, and makes recommendations for future initiatives in employer-based programming. Because of the imperative to increase the share of services borne by the private sector, the paper focuses exclusively on activities with the objective of engendering significant employer responsibility for financing service delivery.

Donor and cooperating agencies have used the following five basic intervention strategies to stimulate employer-based services:

- # Providing direct technical and financial subsidies to employers
- # Conducting analyses of costs and benefits to employers
- # Linking private providers and employers
- # Mainstreaming family planning/maternal and child health services into managed health care systems
- # Working through business and professional associations.

These interventions involve various combinations of inputs, and subproject objectives have varied both within and among them. Accordingly, there are virtually no long-term follow-up data that permit a conclusion as to which intervention works best in terms of any of the disparate objectives.

The paper describes a sample of employer-based programs initiated by PROFIT and other USAID-supported projects, including the Enterprise Project and the TIPPS Project. The purpose of Enterprise (1985-1990) was “to increase the delivery and use of acceptable, affordable family planning services through the private sector.” Employer-based programming was one element within the project's commercial component. The purpose of TIPPS (1985-1990) was “to increase the allocation of private sector resources to family planning by promoting an understanding of the benefits of birth spacing in private health and commercial systems.” The TIPPS approach was designed to stimulate businesses to invest their own funds in family planning services. The goal of PROFIT (1991-1997) is to expand private sector participation in family planning service delivery by encouraging and financing sustainable commercial family planning activities in the developing world.

Based on the experiences of these projects, a great deal has been learned about how employer-based programs operate and about key principles of design, implementation, and evaluation.

### **About Employers**

- # The corporate world is idiosyncratic, and each employer is different, making intervention models unfeasible.
- # Employer-based programming involving a significant corporate investment, with or without a subsidy, requires that the interests of the employer and the donor intersect.
- # Employers have a multitude of priorities, interests, and options for investment.
- # Introducing and/or expanding family planning/maternal and child health (FP/MCH) services is a new activity, requiring a stable economic environment and the commitment of top and middle management.
- # Plantation-type employers, and those with existing health benefits, are more likely to implement an employer-based FP/MCH services program because they tend to have a captive audience and tend to be relatively paternalistic.

### **About Health Insurance Providers and Managed Care Arrangements**

- # Insurance companies are generally conservative, risk-averse, and not primarily socially motivated, resulting in an extremely narrow area of collaborative opportunity in which partner and donor interests intersect.
- # Though experience is limited, the concept of including FP/MCH services within managed care is hard to sell to insurance and managed care companies.

### **About Linking Providers and Employers**

- # Employers generally need specialized technical assistance to establish and maintain FP/MCH programs, even where company health clinics and services exist. Formal linkages between employers, and NGOs and hospitals can serve this need.
- # Intensive brokering assistance by PROFIT-like projects facilitates employer-provider relations.

### **About Working through Umbrella Organizations**

- # Working through umbrella business and professional organizations has excellent potential for achieving economies of scale in costs and facilitating collaboration with employers, provided the partner is committed and effective.

### **About Program Design**

- # Most employer-based programs integrate FP into other existing primary health and MCH services.

- # Multiple donor objectives facilitate flexibility and experimentation. At the same time, multiple objectives can scatter resources and make concrete results hard to define and measure.
- # The typical three- to five-year duration of a project requires more realistic expectations of what can be achieved.

### **About Program Implementation**

- # An opportunistic, ad hoc approach may be as good as, or better than, trying to use a rigid, framework-based approach to choosing partners.
- # All participants in employer-based programming need to resist the temptation of being overly optimistic concerning project goals.
- # Technical assistance is virtually always a prerequisite to establishing employer-based services. It is less clear whether financial subsidies make a substantial contribution toward sustaining or replicating subprojects in the long run.
- # Commercial insurers' clearly need technical assistance and financial subsidies to minimize the financial risk.
- # Simplified data requirements and better management systems are needed for more effective collection and use of project data.

### **About Evaluation**

- # Definitive, scientific evaluation of the impact of employer-based programs is neither possible nor cost-effective at this time.
- # Investment in long-term follow-up may be very beneficial in assessing program sustainability and replication.

### **Future Directions**

USAID-supported approaches to employer-based programming continue to evolve, with implementing agencies continuing to experiment. Flexibility and experimentation remain critical. Past experience suggests that future programming frameworks should incorporate the following key goals:

- # Broaden the area in which partners' and donors' objectives intersect.
- # Minimize direct financial subsidies in light of uncertain long-term results unless there is an overriding reason to do so, as in the case of reducing financial risks within the managed care arena.
- # Carefully identify the partner's technical assistance needs and provide financial support for technical assistance to meet them.
- # Facilitate provider-employer networks through brokering linkages among employers, other for-profit organizations, NGOs, and health care or managed care providers, focusing on providers that require minimal technical or financial assistance.



- # Enlist the cooperation of umbrella business and professional organizations that have strong influence over member employers and can therefore stimulate participation among their members with relatively little support.
- # Disseminate and explore the effectiveness of self-help tools to help employers initiate delivery of FP and other health care services for employees.
- # Engage private sector partners in more business-like activities than simple cost sharing, which would help eliminate those partners who are unwilling to risk their own funds.
- # Improve partner choices, ensuring that the partner can carry out all responsibilities (e.g., start-up financing, quality service delivery, sales, outreach to new populations, etc.) by designing creative subprojects, providing technical assistance, and brokering appropriate linkages with supportive organizations.
- # Continue to integrate family planning into other employer-provided health services, thus building on existing the infrastructure.
- # Set feasible and appropriate objectives given the duration of a project, and refrain from making comparisons between projects based on incomparable measurements.
- # Gather only the data that is most appropriate and useful information for managing and assessing a subproject.
- # Invest in long-term follow-up, particularly if the subproject is meant to be sustained (as opposed to being a pilot).

# 1. INTRODUCTION

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Since its introduction in India during the 1940s, employer-based family planning has been an effective strategy for delivering services to employees in either the formal or informal sectors. Since the late 1980s, diminishing donor funding for family planning programs has focused renewed attention on employer-based approaches as a means to share the burden of providing family planning services with the commercial sector. This paper reviews experience with employer-based initiatives, by identifying strategies used and assessing their effectiveness in motivating employer participation, and makes recommendations for future initiatives. The paper describes a sample of employer-based programs initiated by USAID-supported projects that have focused on employer-based subprojects, particularly the Enterprise Project, the Technical Information on Population for the Private Sector (TIPPS) Project, and the Promoting Financial Investment and Transfers (PROFIT) Project.

The purpose of Enterprise (1985-1990) was “to increase the delivery and use of acceptable, affordable family planning services through the private sector.” The project had both commercial and NGO components. Employer-based programming was one element in the commercial component. The purpose of TIPPS (1985-1990) was “to increase the allocation of private sector resources to family planning by promoting an understanding of the benefits of birth spacing in private health and commercial systems.” The TIPPS approach was designed to stimulate businesses to invest their own funds in family planning services.

The most recent of the three projects is the PROFIT project, which seeks to encourage and finance sustainable commercial family planning activities in the developing world. PROFIT has worked with private sector entities to create, expand, or strengthen their delivery of family planning products and services. It has provided technical assistance and investment funds to projects that:

- # increase the quality and availability of contraceptive products through improved marketing and distribution
- # broaden contraceptive method mix and/or introduce improved products,
- # increase availability of family planning services by establishing new clinics or expanding existing ones,
- # improve the quality of available family planning services through training and access to equipment, and
- # shift product costs and services from the public sector to the private sector.

The employer-based subprojects described in this report are categorized by type of intervention. The categorization scheme highlights the practical aspects of the donor-supported efforts

to stimulate employer participation. This enables donors and implementing agencies to examine implementation strategies as one component in the formulation of future directions.

Section 2 provides brief descriptions of the programs (Appendix A contains more program details and presents results where available). Section 3 summarizes what has been learned to date and suggests implications for future programming. Section 4 presents the key elements of a framework to guide future employer-based program directions.

## 2. STIMULATING EMPLOYER-BASED SERVICES

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This section describes selected employer-based family planning (FP) and/or maternal and child health (MCH) programs, illustrating the diversity of donor-supported initiatives in this area. The distinguishing features of each activity are highlighted. More detailed descriptions of these programs are given in Appendix A and can be found in the other documents listed in the bibliography.

There is ample evidence that many employers will readily accept a free service involving little corporate obligation, except those that have a substantial objection to the idea of family planning services or employee benefits. The current objective of donors and governments is to discontinue such free programs and to shift the financial burden of providing these services to the private sector. Therefore, the experiences of donor programs that provide financial or other support for delivering FP/MCH services without seeking support from the employer to sustain the program over the longer term are not directly relevant and are not included here.

Employer-based subprojects that are presented in this report are categorized by type of intervention, as listed in Figure 1 and described in more detail below.

### **FIGURE 1: TYPES OF INTERVENTIONS TO STIMULATE EMPLOYER-BASED SERVICES**

- C Providing direct technical and financial subsidies to individual employers
- C Conducting business analyses to attract employer participation
- C Linking private providers and employers
- C Mainstreaming FP/MCH services into managed health care systems
- C Working through business and professional associations

### **Providing Direct Technical and Financial Subsidies to Individual Employers**

This type of intervention has involved both financial grant subsidies and a variety of technical support subsidies to promote subproject start-up and to facilitate the establishment of sustained company-based services. The companies have not been responsible for repaying any portion of donor funding but have been required to contribute to the start-up costs. In all cases, FP was integrated into related primary health and MCH services, which, in most cases, were already operating.

These interventions require initial donor seed money and technical assistance and training to initiate employer-based services. Such initiatives may also be labor-intensive, depending on the company's existing health infrastructure, the skills and experience of company staff, and the company's attitude toward providing benefits and social services. In general, this type of program has a relatively rapid impact on both the accessibility of FP services and the number of users served by the private sector. Private sector funds are used initially for start-up costs. Depending on pre-intervention conditions and the nature of the workforce, such interventions may improve the method mix and/or may transfer users from public to private providers. The absence of long-term follow-up data (see Section 3 and Appendix A) precludes making a determination whether employers sustain these services after donor support is withdrawn or whether these programs stimulate independent replication by other companies. If neither of these results can be expected, this intervention can be relatively expensive and inefficient.

Examples of interventions that involve technical or financial subsidies include the following.

*Benguet Gold Operations (BGO), Baguio, Philippines; and Matling Industrial and Commercial Corporation (MICC), Mindanao, Philippines*

Both of these employers were plantation-type companies with large, captive populations and a tangible prior commitment to providing a range of benefits and social services. Both were profitable at subproject start-up but began to experience financial difficulties shortly thereafter. At BGO, Enterprise provided support to revitalize an existing Responsible Parenthood Program, including a cost-benefit study, funding for physical improvements and training, computers, and other technical assistance. MICC's existing plantation hospital provided limited FP, MCH, and nutrition services to employee families and local residents, but facilities and equipment were inadequate. The Enterprise intervention between 1987 and 1990 involved FP staff training, facility upgrades, and development of outreach services. Both companies shared start-up costs.

*Company-Based Programs in Zimbabwe*

Beginning in 1987, Enterprise initially provided technical and financial support to four Zimbabwean employers, including three corporations and the Commercial Farmers Union (CFU). A fourth corporation, impressed with the program initiated at one of the other sites, subsequently joined. All partners contributed to start-up costs, and all had on-site medical facilities. Enterprise provided support simultaneously to the Zimbabwe National Family Planning Council (ZNFPC). Enterprise supported a cost-benefit study at two companies. ZNFPC helped participating CFU employers recruit, train, and deploy community-based distributors. At the companies serving women, ZNFPC trained company nurses in clinical methods. ZNFPC also provided SOMARC commodities.

A 1996 PROFIT assessment of Zimbabwe's private medical sector revealed that more than 200 employers run on-site clinics, many of which provide basic FP services. PROFIT is currently formulating a strategy to increase employer involvement.

*Mawana Sugar Works/Shriram Industrial Enterprises Limited (SIEL), Western Uttar Pradesh (UP), India*

SIEL Ltd. owns Mawana Sugar Works (MSW), a factory employing 1,600 people and interacting with 40,000-45,000 farmers who sell sugar cane to the factory. SIEL is seeking to start a comprehensive MCH and/or reproductive health (RH) program and to contract with an experienced family planning NGO for expertise designing and implementing the program. The NGO would survey needs, implement an IEC program, train health workers, and establish a contraceptive supply system. PROFIT is funding a pre-implementation baseline survey and will fund the three-year program upon approval of the project design.

### **Conducting Business Analyses to Attract Business Participation**

TIPPS developed a comprehensive methodology for analyzing the prospective costs and benefits to the employer of employer-based FP services. The methodology, well documented in TIPPS reports, uses knowledge, attitudes, and practices (KAP) surveys and a cost-benefit model. It generates:

- # the benefit-to-cost ratio, discounted to present value
- # break-even analysis, showing when savings equal or exceed program costs
- # payback period, when the company would recoup its investment
- # internal rate of return, permitting the company to evaluate the economic effect of a FP service investment versus another investment
- # a comparison of the costs of FP or FP/MCH services with the company's overall medical costs.

The TIPPS approach also included professional presentations to company management and a number of employer dissemination activities.<sup>1</sup>

The business analysis intervention is complex and labor-intensive. The methodology has been validated. However, because employers are motivated to initiate FP services by a variety of factors, it is not clear that this level of effort is justified. Also, there are no long-term follow-up data to document how many companies proceeded to establish FP services or, in the case of those that did, whether the programs performed according to projections or whether they were sustained.

Examples of these approaches include the following.

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<sup>1</sup> There have been cost-benefit analyses included in other USAID-funded programs. However, these were not as clearly designed to stimulate new programs, and there has been considerable question about the methodologies used.

*Milpo Mining Company, Peru*

Milpo provides family-related benefits, including housing, to its 800 workers and 4,000 dependents. The 1986 TIPPS analysis estimated that a FP program could more than double the contraceptive prevalence rate (CPR), which was generally lower than the national average, increase the effectiveness of the method mix, and significantly reduce the number of births in the long term. It also projected a positive cash flow in the fourth year, payback by year six, a net benefit-to-cost ratio of over 7:1 in the first five years, and an internal rate of return in excess of 50 percent. The analysis also argued for an integrated FP/MCH module, to allow Milpo to save on the cost of drugs to treat preventable diseases.

*Electrolima Utility Company, Peru*

This parastatal company provides an array of health and other social benefits, varying with employee classification. The 1986 TIPPS analysis projected little change in the CPR, which was higher than the area average, but a significant improvement in method mix. The projected benefit-to-cost ratio ranged from 3.83:1 to 4.19:1, depending on the share of voluntary sterilization. The estimated internal rate of return ranged from 127 to 140 percent. Positive cash flow was projected for year two and payback of start-up costs in year three.

**Linking Private Providers with Employers**

There have been a number of attempts to strengthen private providers, such as hospitals and NGOs, so that they could market both the concept of employer-based services and the capacities of their organizations to provide or assist in providing these services on a contract or fee basis. These initiatives have sought to promote greater responsibility by employers, increased private-private linkages, and diminished NGO dependence on donors.

Interventions to link employers and providers have the potential to supply employers with both motivation and expertise related to establishing and operating employer-based FP services. They generally require technical assistance to providers for packaging and marketing their services. Depending on the capacities and philosophical orientation of the provider, this technical assistance may be expensive and labor-intensive. Experience with this type of intervention has been limited, but it does suggest a need for caution in relying on NGOs to collaborate with employers in ventures other than the provision of simple support services. As with the other interventions, there is little long-term data on whether provider-employer relationships or employer-based services continue after donor support has ended.

*Atma Jaya Hospital, Jakarta, Indonesia*

In 1986, this private hospital started providing FP services at 20 small and medium-sized factories. The program was fully subsidized by Family Planning International Assistance (FPIA). With TIPPS support, in 1987, Atma Jaya tested development of a hospital-factory service program for which employers would pay. The activity involved initial cost-benefit analyses at selected factories, assessment of hospital capacities, determination of service delivery costs (to facilitate pricing), design of four individually priced service modules, and marketing to employers.

*Federacion Mexicana de Asociaciones Privada de Salud y Desarrollo Comunitario (FEMAP), Mexico*

FEMAP, in Juarez, is a national federation of 32 family planning NGOs. Enterprise helped FEMAP develop its capacity to sell FP services to industry. There were two subprojects, one to establish FP programs in 10 to 20 in-bond maquiladora companies in Ciudad Juarez (1989-1990) and the second to establish FP programs in nine General Electric (GE) factories in northern Mexico (1989-1990). Women constitute two-thirds of the maquiladora work force. GE was already contributing to the national social security program. FEMAP repackaged its traditional FP services to be more attractive to GE. The package included occupational health and safety, X-ray, ultrasound, family medicine, and family planning.

*Philippine Center for Population and Development (PCPD)*

Formerly the Population Center Foundation, PCPD has been working in the industrial sector since 1985 helping companies establish in-plant MCH/RH programs. In three waves, PCPD refined its service package, recruitment strategies, and pricing schemes (although cost recovery has not been a major objective). The first wave involved 30 companies, the second 21 companies (with Enterprise contributing to PCPD's support during this period), and the third 60 companies. PCPD's involvement with each company spans about three years, with the company taking responsibility thereafter. PCPD currently supports information, education, and communication (IEC) activities, training in-plant teams, orienting labor unions, conducting cost-benefit analyses, establishing referral systems, conducting research and evaluation, involving company personnel in planning and institutionalization, and facilitating area coordination among companies, NGOs, and government. Third-wave companies are required to pay for IEC services.

*Jakarta Industrial Estate PuloGadung (JIEP) and Yayasan Kusuma Buana (YKB)*

JIEP is a government-run industrial estate with an underutilized on-site medical clinic. An Enterprise-United Nations Population Fund (UNFPA) study concluded that an HMO on the estate would be financially viable. YKB, an NGO with experience in developing private FP clinics, was identified to run the HMO on a contract basis. However, JIEP was not interested in this venture, and a 1993 PROFIT survey revealed that companies were wary of joining HMOs. However, PROFIT supported a market test of two service packages by YKB, in response to its interest in mobile preventive health services. One was a basic package of FP and preventive health services, including individual and family counseling. The other was a supplemental package including contraceptive products and services, chest X-rays, and vaccinations. Cost recovery was the principal indicator of success. In addition to completing the test, this subproject produced promotional materials and training manuals on FP methods and counseling, trained clinic personnel, and refurbished the on-site clinic.

## **Mainstreaming Family Planning/Maternal and Child Health Services into Managed Health Care Systems**

This is the newest type of intervention, and activities range from simply assessing the feasibility of managed care arrangements to generating new packages and marketing strategies within existing managed



care systems. One, in the Philippines, targets that nation's large, informal self-employed sector, with some marketing targeted toward associations of self-employed workers.

This “mainstreaming” strategy is a relatively high-risk intervention focused more on innovative managed care programs (expanding coverage to new populations and including FP in service packages), though it also has the potential to help achieve FP objectives in the very long term. With the exception of a few nonprofit organizations, managed care organizations are generally conservative, commercially oriented, and risk-averse. Therefore, donors must be prepared to provide financial subsidies. In addition, these organizations generally require substantial technical assistance in such areas as designing and managing new coverage, marketing to new populations, and establishing linkages with new providers. Thus, these kinds of subprojects may be very labor-intensive in both the negotiation and the implementation stages.

#### *Feasibility Study for Sankalp Kiran, India*

Sankalp Kiran is an NGO service provider. Between 1989 and 1991, an Enterprise subproject assessed the feasibility of establishing an HMO to serve employees and dependents of 26 large and medium-sized companies in South Delhi. Findings showed that the venture was feasible if companies could be persuaded to switch from a fee-for-service to a prepaid arrangement. Viability would depend on modest premiums, large volume, and cost control. The need for start-up capital was high, return on investment was not attractive, and the minimum break-even point was estimated to be five years.

#### *Commercial and Industrial Medical Aid Society (CIMAS), Zimbabwe*

CIMAS is Zimbabwe's largest medical insurance company and is a nonprofit organization. The objective of a 1987 TIPPS analysis was to convince CIMAS to add family planning to its benefits package. Most women (64 percent) were obtaining methods from Zimbabwe National Family Planning Council (ZNFPC). The introduction of CIMAS coverage was projected to shift users to private providers. The cost to CIMAS would be high, and the FP benefits low. TIPPS then persuaded ZNFPC to provide services exclusively to CIMAS beneficiaries at twice or three times the price charged to regular ZNFPC clients. CIMAS later allowed its enrollees to receive services from private providers but placed a cap on the amount reimbursed.

#### *Adding Family Planning to Health Insurance Coverage in Jamaica*

PROFIT explored two opportunities with insurers in Jamaica. With Blue Cross of Jamaica (BCJ), a nonprofit division of Group Hospitalization and Medical Services, Inc. (GHMSI), of Washington, DC, the objective was to expand health coverage to include family planning. This would require upgrading BCJ's claims-processing and management information system (MIS). Under a joint venture, PROFIT was to supply computer hardware, assist in market research and FP product development, and establish a coinsurance or reinsurance fund as a source of ongoing funding. GHMSI was to be used for software and training senior management. GHMSI ultimately was unable to meet its commitment.

The second initiative was to focus on including family planning in the coverage provided by BCJ and four other for-profit insurance providers that offer life insurance as well.<sup>2</sup> This was to target large employers, with the objective of adding family planning to prepaid coverage. The Jamaican Family Planning Association would be the service provider. PROFIT's contribution was to offset the cost to the companies of increased claims generated by the new coverage through establishment of a coinsurance/reinsurance fund. However, an analysis showed that the cost savings that would result from the decrease in medical claims would not cover the costs of implementation.

#### *UNIMED Maceio, Brazil*

Among the world's largest HMOs, UNIMED is a cooperative of Brazilian physicians which directly provides medical assistance, diagnostic services, and hospital care. There are 196 local cooperatives, each of which is a separate legal and financial entity. Through a joint venture, PROFIT and UNIMED/Maceio, one of these cooperatives, negotiated to purchase, renovate, and run an existing hospital.<sup>3</sup> UNIMED had a 51 percent interest, and PROFIT provided \$1.1 million in investment and technical assistance. Basic to this co-investment was UNIMED's agreement to establish an FP/MCH clinic at the hospital and to include family planning in the covered services. The subproject also included marketing HMO services to employers whose employees were not enrolled in the UNIMED HMO and were less likely to have access to health care or FP services. This agreement has not worked out particularly well. The clinic opened in August 1995, but utilization has been low and has focused more on pediatric rather than FP services. A local accounting firm is now doing a pre-buyout analysis for PROFIT's divestment.

#### *PhilamCare Health Systems, Inc., Philippines*

PhilamCare is the leading Philippine HMO. In 1992, PhilamCare had 20 percent of the national HMO market and served 100,000 plan members, mostly group enrollees in three plans that targeted the formal sector. A 1991 study examined the feasibility of expanding managed care to the informal sector, which is not covered by national health insurance. The study was not particularly encouraging but suggested a test of the market. A follow-up feasibility study showed potential for such a program, and in 1994 PhilamCare began offering a low-cost health care option called HealthSaver to low-income Filipinos. Providers are paid on a capitation basis, and each enrollee is limited to a designated facility. Family planning is included in the package, but this objective is secondary to that of testing the low-cost capitation model. PROFIT is providing technical assistance and a no-interest loan to PhilamCare to cover initial losses.

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<sup>2</sup> PROFIT determined that, after the BCJ initiative failed, there were no further opportunities in Jamaica to work with life insurance companies.

<sup>3</sup> PROFIT originally had approached a for-profit Brazilian HMO that ran its own hospitals and which had expressed interest in a joint venture to set up a family planning facility in Sao Paulo. However, PROFIT did not pursue this opportunity as US preferred that PROFIT focus its efforts in northeastern Brazil.

### *African Air Rescue (AAR) Health Services, Kenya*

AAR Health Services is a high-quality, well-organized insurance company offering prepaid coverage for health services primarily to high-end employers and individuals. AAR is the only health insurer in Kenya that operates its own outpatient facilities in Nairobi and Mombasa, though these facilities did not provide FP services. PROFIT explored two ventures with AAR. The first was to involve AAR marketing primary health services to Sulmac, a large employer in the Lake Naivasha region. Sulmac offers excellent health benefits to its employees and was being asked by the government to serve others in the region. Sulmac's clinic-related costs were rising, and the company was considering hiring another entity to manage the clinic. A PROFIT loan would facilitate AAR's investment, and PROFIT would provide technical assistance.

In the second venture, PROFIT is making a six-year loan to AAR at slightly below commercial rates, enabling AAR to establish a primary care clinic in the Nairobi industrial area, along with three outreach clinics in residential areas, and to sell a prepaid service package to area companies that includes family planning. PROFIT is also providing technical assistance for FP training. The PROFIT agreement requires AAR to provide FP at these facilities.

## **Working through Umbrella Business and Professional Associations**

Some initiatives work through business and professional associations in an attempt to capitalize on economies of scale in costs and to facilitate collaboration with employers, as well as to reach employers to try to engage them in in-plant service delivery.

This type of intervention requires considerable support from the donor to the partner association. This support takes the form of technical assistance and, often, start-up funding. While this type of program is attractive to many professional and business associations, it may require skills that do not exist within the organization and may involve a commitment to add new objectives to the association's portfolio. While these organizations may be excellent vehicles for information dissemination, it is less clear that they can and/or will actually stimulate the establishment of employer-based FP services among their members.

### *Personnel Management Association of the Philippines (PMAP), Cebu Chapter*

From 1988 to 1991, Enterprise supported PMAP in persuading 30 member Cebu companies to introduce in-plant FP services. This subproject also involved a number of other entities and subsidies. Once companies agreed, the Cebu Chapter of the Family Planning Association of the Philippines (FPOP) trained clinic staff, delivered motivational lectures, and provided supplies to in-plant distributors who then sold them, keeping a commission on sales and returning any unsold supplies to FPOP. The Population Center Foundation (PCF),<sup>4</sup> under contract to PMAP, developed and produced IEC materials and conducted special training for PMAP and the Department of Labor and Employment (DOLE). An area university was slated to conduct baseline studies and evaluation, but PMAP eventually assumed responsibility for this.

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<sup>4</sup>now the Philippine Center for Population and Development (PCPD)

*Indian Chamber of Commerce (ICC), Calcutta*

Supported by Enterprise between 1988 and 1991, ICC identified companies to receive assistance in establishing employer-based FP programs. Sankalp Kiran was slated to provide technical assistance. ICC had little or no continuing involvement. No in-plant motivators were trained, and all services, including temporary methods distribution, were provided off-site. Limited IEC materials were available, and management involvement was minimal.

*All Indian Organization of Employers (AIOE)*

This Enterprise subproject worked through AIOE headquarters in New Delhi between 1988 and 1991 to stimulate program implementation in underserved areas by three local employer federations. The goal was to establish in-plant FP programs in up to 60 industries and in the informal sector. The target was 30,000 workers in each area. The motivators distributed pills and condoms to coworkers and in the community. Subproject officers and motivators referred users to public and private area facilities for other methods and for counseling.

*Confederation of Indian Industry (CII)*

In response to USAID's interest in disseminating information on employer-based FP as well as to corporate inquiries directed to CII, PROFIT supported the development of a users' manual showing companies how to become involved in FP programs. This manual will be launched in 1996.



### 3. LESSONS LEARNED

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The U.S. Agency for International Development has more than 10 years of experience in working directly with employers, accessing employers through umbrella professional organizations, and stimulating linkages between employers and service providers to establish FP services in the workplace. The number of initiatives is still a small proportion of all USAID FP efforts, and the objectives have varied considerably from subproject to subproject, and have included increasing contraceptive prevalence, transferring users from the public sector, leveraging funds, introducing FP services into insurance coverage and/or other service delivery programs. Because of the variety of objectives, these projects have yielded a variety of results. For example, the initiatives may have documented CYP, others cost per user, number of users (new and/or transferred), the corporate contribution, and/or the number of companies benefiting from donor-subsidized NGO services. This variability—while appropriate to experimental programs—nevertheless precludes comparing one initiative against another using a common standard. Also, even for those activities that have generated data about whether they met their objectives (which themselves are usually somewhat process-oriented), there is no long-term follow-up data available to show whether the initiatives were sustained and, if so, what overall effect they had on birth rates.

Experience with insurance companies and other managed care arrangements is far less broad and much more recent—many of these initiatives are still under design or in process. Thus, there are little data on which to assess even the short-term, process-oriented outcomes of these initiatives.

Despite the absence of definitive answers to questions about what works and what doesn't, past experience has yielded considerable information about the circumstances in which these programs operate as well as key principles of design, implementation, and evaluation. This section highlights what has been learned to date and, where appropriate, suggests implications for future initiatives to establish employer-based reproductive health services. Section 4 ("Future Directions") incorporates findings from this section to suggest future directions.

#### **About Employers**

Experience to date with employer-based programs provides valuable guidance about the orientation and needs of employers and about the relative potential of various types of employers to be suitable partners for initiatives to launch or expand company-based services. Figure 2 summarizes these lessons.

### FIGURE 2: ABOUT EMPLOYERS

1. Each company is different.
2. Employers' and donors' interests must meet on common ground.
3. Employers have a multitude of priorities, interests, and options for investment.
4. A stable economic environment and the commitment of top and middle management commitment are essential.
5. Employers with a prior commitment to advance their employees' welfare and to provide health services are the best prospects.

#### *1. Each company is different.*

The motivation to establish or decline to establish FP and RH services vary from one company to another. For example, in the case of the PCPD program (Philippines), a primary motivation was to improve labor-management relations. On the other hand, a fear of negative labor relations, along with economic factors, dissuaded Sulmac (Kenya) from adding family planning to the primary health services provided. Meanwhile, Milpo Mining (Peru) was clearly influenced by the potential savings and the return on investment. Others, benefiting from the same analysis and similar predictions, failed to act. Electrolima (Peru), for example, is a monopoly operation that may find simply raising its rates easier than offering a new benefit program. Other motivations may include improving the company's image with government, as was the case for farmers in Zimbabwe before the land reform policy. The management of BGO (Philippines) had long been a strong supporter of family planning and a strong believer in corporate responsibility. This was not true of other Philippine companies, despite a law that requires the provision of in-plant FP services at larger facilities, and both PCPD and PMAP have had difficulty recruiting companies.

In trying to persuade employers to participate, it is essential to recognize the unique character of each organization and to market both the idea and an implementation strategy accordingly. The variability of motivations suggests that expensive intervention "models" may not be justified. The prospect of taking a blueprint or cookbook approach is very attractive because it would be a very efficient way to increase the number of employer-based programs. However, such an approach is not feasible, aside from providing some very broad guidelines. It is more important to get a sense of each company's concerns, assets, and interests and to devise an intervention to specifically respond to these than it is to promote the benefits of a model that requires companies to reformulate their objectives.

Economic considerations are not always the overriding motivation for employers to provide family planning. This raises questions about the value of costly, time-consuming, data-rich, and labor-intensive surveys and analyses which consume donors' resources as well as employers' time. A less complex, less precise analysis that incorporates the employer's specific situation may be sufficient to make the case for the employer. This was the conclusion of TIPPS, which suggested a simpler process in its final report. Such an approach may not reach the level of precision desired by researchers and donors. However, if the goal is to stimulate employers to buy in, then it would seem that the objective should be to respond only to the company's needs. Also, much of the corporate information required to conduct detailed analyses is simply

not available or is considered by the company too confidential to divulge. Thus, TIPPS often had to make normative estimates, calling into question the accuracy of the projections.<sup>4</sup>

2. *Employers' and donors' interests must share common ground.*

Employer-based programs involve a significant corporate investment, whether or not a subsidy is provided, which requires that the interests of the employer and the donor intersect. At a general policy level, the employer's interest is quite limited and generally unrelated to donors' or governments' concern for expanding FP services or reducing public health expenditures. For example, the employer's interest is generally not grounded in a desire to increase contraceptive prevalence or reduce birth rates nationally. As a result, the potential intersection of donors' and employers' interests is generally very narrow. This intersection usually occurs when provision of services furthers the employer's interests (e.g., including improving labor relations, generating a desirable return on investment, positioning the company favorably in the eyes of government, reducing the employer's social security payment obligation, giving the company a competitive advantage in hiring and/or retention) *and* meets a donor's objective for privatizing services or refining strategies for employer-based service delivery.

Employers are generally not interested in transferring users from public sector providers to private providers, although this may be one result of an employer-based program. Indeed, in many countries, employers view FP/MCH services as a traditional obligation of government. If employers decide to offer such services, there is no reason for them to care whether the users are new or whether they are transfers from another private provider, unless the employer has been paying that provider. In the latter case, the employer may be interested in the relative cost and/or cost-benefit of becoming, in essence, an alternative private provider. In cases where public services are not sufficiently available or accessible, employer-based services will not transfer users but will generate new ones.

The advantages resulting from making the potential area where employers and donors interests intersect as wide as possible suggest that USAID projects continue to have multiple objectives and to be flexible in experimenting with strategies that work at different paces and toward different short-term ends. For example, the PhilamCare subproject (Philippines) is an experiment in health care financing, but it has involved a private insurance company in a new effort that may offer guidance to future FP work in the insurance sector.

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<sup>4</sup> PCPD has successfully used simple brochures documenting individual companies' experiences in its corporate recruitment efforts. There are no hard data on which to compare the effectiveness of this strategy with that of a business analysis in motivating companies to establish services. However, this does suggest that, in selected cases, an example of benefits gained elsewhere may be a sufficient basis for a company's decision.



3. *Employers have a multitude of priorities, interests, and options for investment.*

USAID-supported programs geared to increase employer participation generally focus only on the pluses and minuses of employer responsibility for provision of FP/MCH services, directly or indirectly. This is understandable because funding is generally earmarked for these services alone. However, the employers themselves have a very different orientation. In considering whether to provide these kinds of benefits, they weigh the advantages and disadvantages in comparison with other options they may have to reduce costs, increase profits, maintain a recruiting advantage, lower absenteeism and the use of sick leave, generating goodwill among their workforce, and achieve corporate objectives in general. This is why not all companies elect to provide such services, even when they are shown clear financial and other advantages of doing so. For example, an employer concerned with increasing productivity and reducing costs may invest in automating a plant operation, training workers, providing another kind of benefit more in demand, or refinancing. In addition, corporate providers of FP/MCH services, both employers and insurers, take a much longer-range view than their donor-supported partners: they are interested in the potential effect and benefit over 10, 20, or more years; the end-of-project results are not a priority concern.

Analyses of the internal rates of return on investment allow companies to weigh the relative benefits of proving health services against other options for investing money, time, or efforts. The projects supported generally have found no way to determine why an employer opts **not** to take advantage of what seems to be a viable corporate opportunity—a rationale that employers are unlikely to share with outsiders,<sup>5</sup> leaving subprojects like PROFIT unable to apply potentially important lessons from these experiences.

There is little that USAID can do to compete directly with the other investment options available to companies. However, implementing agencies may be able to gain a deeper understanding of a candidate company's business situation and to develop a more individualized sales pitch. This could enhance the credibility of the subproject sales team and broaden the dialogue with the employer. However, this is a labor-intensive activity that may reduce efficiency.

4. *A stable economic environment and the commitment of top and middle management are essential.*

Time and again, reviews of and reports on donor-supported efforts have identified two key factors that facilitate the implementation of company-based FP/MCH programs: a stable economic environment and the commitment of top and middle management. These factors affect decisions about everything in the corporate environment—plant expansion, new products, automation, investment, borrowing, and employee benefit programs. In an unstable and/or highly inflationary economic environment, companies find it impossible to predict the outcome of a long-term investment and are generally risk-averse. Companies in most parts of the world are still highly autocratic, with power and information closely held at the top. Top managers make the decisions, and middle managers carry them out.

The need for a stable economic environment and a committed management may at times conflict with the development perspective that motivates donors and implementing agencies. First, many developing

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<sup>5</sup> Electrolima is an exception, apparently sharing its rationale freely with TIPPS.

countries offer the antithesis of a stable economic environment, and these countries are often high priorities for donors for precisely that reason. Second, public sector donors and many of their implementing agents have little familiarity with how the corporate sector thinks and behaves. The participatory process that works so well at the community level finds no home in most corporations.

Given the exigencies of USAID's mandate, it is impossible to predict or guarantee economic stability. However, employer-based programming could be restricted to more stable countries if the primary objectives are long-term. Also, USAID could continue to expand its resources to include implementing agencies that are more knowledgeable about the corporate world.

*5. Employers with a prior commitment to advance their employees' welfare and to provide health services are the best prospects.*

This is common sense. Plantation-type employers (such as mines, tea estates, farms, and isolated agricultural production and refining operations) have a captive audience and tend to be relatively paternalistic. Company owners and/or senior managers live in the community and have daily relationships with their workers. For their own benefit as well as that of their employees, they often provide housing, education, recreational, health, and other services to their workers and sometimes to others in the surrounding community. In many cases, the employer is so remote that there are no public services. Often, FP/MCH services can be integrated at minimal cost into existing services, for example, at company hospitals and clinics.

While it may be harder in rural areas than in urban settings to provide the technical support required to establish high-quality services, employers in rural areas are more likely to incorporate new services if (for whatever reason) management chooses to do so. Urban employers are likely to provide fewer social services and to have a far less personal relationship with their workforce. However, those that already provide health benefits, either through in-plant facilities, company medical benefits packages, or insurance, are generally more receptive to providing FP/MCH services if management sees a benefit in doing so. These companies already embrace the concept that they have some responsibility for their employees' (and sometimes dependents') health. Moreover, like the plantation-type employers, they already are spending money on benefits, and therefore there is the potential to achieve some savings over establishing a new program. The only challenge is to persuade these companies that additional services should be added to the health program. This may be a significant obstacle when the employer considers FP/MCH services to be a public responsibility, as many do.

In working with these types of companies, USAID may be able meet only a selected number of its objectives. For example, projects may or may not increase contraceptive prevalence, transfer users, leverage significant funds (because costs are often merely incremental), and/or be cost-effective from the public sector perspective.

## About Health Insurance Providers and Managed Care Arrangements

Although experience is relatively limited, it does suggest the significant challenges associated with working in this area. Figure 3 outlines the two main constraints on expanding the provision of FP/MCH services by health insurers and under managed care systems, which are explained in more detail below.

### FIGURE 3: ABOUT HEALTH INSURANCE PROVIDERS AND MANAGED CARE ARRANGEMENTS

1. Insurance companies are generally conservative, risk-averse, and not primarily socially motivated, resulting in an extremely narrow intersection of shared interests with donors and few opportunities for collaboration.
2. The concept of including FP/MCH services within managed care is hard to sell to health insurance and managed care companies.

1. *Insurance companies are generally conservative, risk-averse, and not primarily socially motivated, resulting in an extremely narrow intersection of shared interests with donors and few opportunities for collaboration.*

While nonprofit insurers such as CIMAS (Zimbabwe) have social as well as business objectives, most insurance providers have purely commercial interests. They have calculated and understand the risks associated with their existing health coverage, and they are wary of adding new kinds of coverage. Unlike employers that have a more or less direct relationship with and (sometimes) feel socially obligated to their employees, most insurance providers are one step removed from their policyholders. Even those that run their own service facilities have a far weaker link to their clientele than most employers. Furthermore, many existing insurance plans exclude family planning. Expanding existing plans to include FP services could easily reduce the companies' earnings. The result is that most insurance providers require some form of subsidy even to experiment with expanding coverage to reach new market segments and or to include new services, such as family planning, in the mix of other, more profitable reproductive health services.

2. *The concept of including FP/MCH services within managed care is hard to sell to health insurance and managed care companies.*

In the countries where USAID works, private providers generally face huge competition from free public sector health service providers, serve higher-income groups, and challenge the introduction of managed care. In addition, there is often a tradition of public responsibility for basic health care and large concentrations of poor people in these countries. There is little on-the-ground experience with the economic consequences of including FP/MCH in general health plans, and it is hard to convince private providers that such a move would not have a negative effect on their balance sheets. There are also traditions of medical practice that generate considerable resistance to managed care, as in the United States. Further, given the unpredictable nature of the market, it is hard to prove, even on paper, that such a concept is viable. One example is the Sankalp Kiran study which showed that a huge investment would be required and that the returns were questionable.

This does not mean that USAID should not continue to experiment with this concept. The PhilamCare program has already revealed the potential, while demonstrating the need to carefully select provider partners and to reorient the sales force. If the HealthSaver plan works for PhilamCare, the participating hospitals, and the enrollees, it may provide some positive direction for future initiatives. The same is true for the AAR program in Kenya.

The prospect for NGO-run HMOs is less promising. Even if feasibility study findings were positive (which was not the case in India with Sankalp Kiran), it is questionable whether NGOs could operate such a venture successfully in the long run—this is true even for the best run NGOs that are becoming less donor-dependent. While they might be able to deliver services and perhaps even contain costs, there is some question as to whether they could successfully market to and negotiate with area corporations to generate a big enough client base to be profitable and then whether they could keep their clients.

Because experience is so limited, this is an area where USAID experimentation could make a major contribution. These are high-risk ventures, and little is known about the long-term outcomes. It seems clear that profitability is an overriding motivation and that several factors work against success, including conflicts with the interests of provider members (as in UNIMED), the tendency of employers to prefer general medical and other health packages over family planning (as in Atma Jaya and JIEP), or lower commissions for sales agents (as in PhilamCare). Clearly, to work in this arena, USAID can expect to provide a subsidy, or, at a minimum, to guarantee losses. USAID can also expect to face long developmental periods, to achieve only a narrow set of objectives at best, and to experience a number of failures.

## About Linking Providers and Employers

This type of intervention generates high interest because of the appealing possibility of establishing self-sufficient networks of private entities and thereby contributing to the privatization of FP services. There is a clear need for these independent networks, and those participating in them are refining some models that are potentially replicable.

### FIGURE 4: ABOUT LINKING PROVIDERS AND EMPLOYERS

1. Most employers need technical assistance to establish and maintain FP/MCH programs.
2. An outside source can broker arrangements between providers and employers.

*1. Most employers need specialized technical assistance to establish and maintain FP/MCH programs.*

This is true even where company health clinics and services exist. Formal linkages between employers, and NGOs and hospitals can meet this need. Typical areas requiring technical support are organizing clinics, other aspects of starting up a facility or a new service, IEC, staff training, medical supervision, commodity supply systems, record keeping and/or assessment, and establishing referral networks. All of the companies mentioned in Section 2 benefitted from some technical support, which was either directly funded by an USAID subproject or purchased (in full or in part) from an NGO or private hospital. Where the NGO is qualified and can package its services in a way that is attractive to the employer, this type of arrangement has worked well, sometimes meeting USAID's objectives for lessening donor dependency among NGOs as well as for increasing financial participation by the corporate sector. What is less clear is whether the total cost to donors, including any subsidies paid to the NGO, is greater or less than what would be involved in providing a direct subsidy to the company for the same purpose. The long-term viability of these arrangements also is uncertain. In any event, these linkages are often necessary; they can work well under the right conditions and with the right partners; and they can help involve many segments of the private sector in FP/MCH services.

*2. An outside source can broker arrangements between providers and employers.*

Intensive brokering assistance by PROFIT-like projects facilitates employer-provider relations. Employers are generally far removed from NGOs and for-profit institutions that provide FP/MCH services. This is true even in companies that have existing benefit arrangements with outside providers. Similarly, NGOs and for-profit health care providers rarely have experience in dealing with industry. Their services may not be attractively packaged or responsive to employers' needs. Also, these organizations may be less than expert at or resistant to costing and pricing their services. This situation—which is complicated by the different orientations of providers and employers—makes outside brokering particularly valuable. This also has the potential to be a low-cost intervention because it involves no direct funding to either party from the donor and therefore may help promote more sustainable arrangements.

Many USAID-supported subprojects have served this brokering role. Even at Milpo Mining, which received no program subsidy, TIPPS assisted in identifying and facilitating agreements with the two service NGOs. Brokering, as distinguished from direct support to strengthen NGO capacities, may be a cost-effective and valuable USAID contribution.

## **About Working through Umbrella Business or Professional Organizations**

This strategy has obvious appeal because it is potentially simple, efficient, and economical. More experimentation is needed to determine whether this potential can be realized, but Figure 5 shows one issue that is already clear.

**FIGURE 5: ABOUT WORKING THROUGH UMBRELLA BUSINESS  
OR PROFESSIONAL ORGANIZATIONS**

1. A committed and effective partner is critical to success.

*1. A committed and effective partner is critical to success.*

Working through umbrella business and professional organizations has excellent potential for achieving economies of scale in costs and increasing access to FP services, provided the partner is committed and effective. Experience with umbrella business and professional organizations is mixed. Where objectives included strengthening the umbrella organization as well as stimulating employer-based services, as in AIOE (India), results were disappointing. In the case of PMAP (Philippines), which focused only on program development, results were more encouraging, although PMAP had difficulty recruiting the target number of companies (perhaps because the personnel managers who are PMAP's members may not have enough clout with top management).

While these two cases are insufficient to support generalizations, it seems logical for USAID to work through organizations that are already sufficiently strong, have power and prestige among their employer members, are not encumbered by multiple bureaucratic components such as regional federations or affiliates, and do not have to create an expensive infrastructure to administer the program. The results of work with CII (India) bear watching and may shed more light on successful ventures with umbrella organizations.

**About Future Program Design**

USAID has funded a number of initiatives designed to increase employer participation in and responsibility for providing FP/MCH services in the workplace. The contractors and grantees implementing these initiatives in turn have designed individual activities or subprojects targeted to specific companies and agencies. This section assesses this experience for guidance in broad program design in the future.

**FIGURE 6: ABOUT FUTURE PROGRAM DESIGN**

1. Integration of family planning with existing MCH and other services helps sell family planning.
2. Programs are still experimental and need flexibility. Each works toward its own unique objectives.
3. Expectations should be realistic.

*1. Integration of family planning with existing MCH and other services helps sell family planning.*

All of the individual employer initiatives described in Section 2 involved adding or enhancing FP services to existing health programs. Although USAID funding was directed to the FP component only, from the employers' perspective, these were integrated health services. The same is true for Atma Jaya Hospital (Indonesia), FEMAP (Mexico), the JIEP/YKB program (Indonesia), and the insurance and managed care initiatives. This reflects not only the inherent relationship between family planning and other health services but also the relative ease with which these services can be absorbed under a general health umbrella. In other private sector initiatives that involve establishing independent FP services within the marketplace, the risk that FP services are unprofitable (especially without sterilization, IUD, and abortion services) has been a deterrent. In the employer-based setting, cost seems less important than the ease of implementation. Experience suggests that the focus should continue on employers and insurers where the opportunity exists for integration.

*2. Programs are still experimental and need flexibility. Each works toward its own unique objectives.*

Multiple donor objectives facilitate flexibility and experimentation. At the same time, multiple objectives can scatter resources and makes concrete results hard to define and measure. In various combinations for various projects, USAID's objectives in stimulating employer-based programs have included creating sustainable (e.g., non-donor-funded) service delivery operations (either in-plant or under contract), leveraging private sector funds for FP/MCH services, increasing the volume of services provided by the private sector, transferring users from public to private service providers, increasing contraceptive prevalence, and providing cost-effective services (as defined in terms of the public sector cost per acceptor or CYP). No single activity is likely to accomplish all of these objectives. For example, the objective of increasing contraceptive prevalence may conflict, at the operational level, with the objective of transferring users from public to private sources if a candidate company's employees are already largely users. A minimal employer investment may create a company-based program that increases contraceptive prevalence or transfers users from the public sector, but may not result in significant funding leveraged.

Using multiple objectives and allowing the selection of unique combinations for each subproject sets reasonable boundaries while simultaneously encouraging flexibility and experimentation. Given that most initiatives are at or near the first-generation level and do not yet involve tested models, there must be some freedom to test the waters further. However, in continuing this approach, USAID needs to recognize that truly scientific comparison will be impossible. There will be no single standard against which to measure results, and data—if they are truly meaningful and related to individual subproject activities—will vary across subprojects (see "About Evaluation" below).

### 3. *Expectations should be realistic.*

Expectations should be more realistic about what can be achieved during the typical three- to five-year project period. In many respects, three to five years is an adequate period for initial experimentation. However, because activities rarely start on day one and many are initiated only after several years, three to five years is not long enough to see the full fruits of all initiatives. Moreover, some activities develop much more slowly than others, particularly those that involve reorienting insurance companies or introducing new coverage or managed care schemes. Even for simpler activities, such as initiating services in a single company, the typical time frame may not allow for a full test of the individual program and certainly not for a test of sustainability or replicability. Finally, project goals often involve reducing fertility or increasing contraceptive prevalence; given their size, these kinds of subprojects are unlikely to affect these measures and certainly not by the project's end.

## About Program Implementation

Making judgments about the relative efficacy of various strategies and models would be premature. Little is known about the long-term status or viability of the employer-based portfolio, and the diversity of such efforts precludes comparisons. Nevertheless, there are certain implementation trends that are becoming clearer.

### FIGURE 7: ABOUT PROGRAM IMPLEMENTATION

1. An opportunistic, ad hoc approach may be as good as or better than a rigid, framework-based approach in choosing partners.
2. All participants in employer-based programs need to resist the temptation of being overly optimistic about project goals and outcomes.
3. Employers need technical assistance; it is not clear that financial subsidies make a long-term difference.
4. Commercial insurers and conservative managed care organizations usually require a financial subsidy as well as technical assistance to minimize their risks.
5. Simplified data requirements and better management systems are needed to more effectively collect and use project data.

### 1. *An opportunistic, ad hoc approach may be as good as or better than a rigid, framework-based approach in choosing partners.*

Most projects have established a framework of criteria governing the selection of partners. Typically these criteria include company size, type of industry, financial status, potential to influence others, geographical location, benefits policy, workforce age and gender distribution, contraceptive prevalence among workers and/or the surrounding community, and willingness to bear or share costs, among others. Though time-consuming, these frameworks are fundamentally valid tools for managing the selection process.



However, it is rare that such an approach is fully implemented. An opportunistic approach may work equally well, if not better. If a donor, an implementing agency, or anyone else involved can suggest a likely partner based on prior knowledge, it may be far better to take advantage of the opportunity, even if this partner does not meet all the formal criteria. This has certainly been the practice, if not the policy, in the past. Given the obvious challenges in recruiting partners, the merits of seizing such opportunities versus adhering to standard criteria need to be carefully considered.

In fact, USAID often influences partner selection, particularly when it already has a relationship with and investment in a potential partner. This was certainly true with respect to PCPD and many of the ventures in which YKB has been involved. USAID may also focus its efforts in selected parts of a country that rule out certain partners, as was the case with the private HMO in Brazil. These local USAID preferences may or may not conflict with the project's independent criteria, but they will always strongly influence partner selection and hence the project outcomes.

To the extent that a framework for partner selection can facilitate good decisions, it is useful. However, this kind of programming will continue to be influenced by other dynamics, including local networks and relationships among employers and associations and USAID policies and practices. The challenge is to use whatever process is feasible and helps make appropriate choices.

*2. All participants in employer-based programs need to resist the temptation of being overly optimistic about project goals and outcomes.*

It is tempting to think that a relatively small, short-term infusion of funding and technical assistance can quickly generate large changes, but more realistic expectations might help USAID, implementing agencies, and other partners focus on the factors and strategies that promote more reasonable outcomes.

The record is replete with examples of programs that take far longer than planned to get up and running, fall behind in reaching targets, cost more than initial estimates, need additional inputs, or are beyond the capacity of the partner. For example, the absence of certain data and the complexity of carrying out surveys turned the TIPPS analysis into a undertaking that took far longer than anticipated. Both PMAP and PCPD overestimated the ease with which they could recruit participating companies. In many of the linkage initiatives, there was an unexpected need for assistance in brokering relationships between companies and service providers. Agencies like AIOE simply lacked the management infrastructure to carry out the program. In addition, potential market size, ease of access to potential markets, and the potential returns have been overestimated in numerous subprojects.

This over-optimism may be a result of the implementing agency's desire to convince USAID of the worthiness of its investment or to meet contract requirements. In other cases, over-optimism has been a consequence of design or implementation flaws or unanticipated events or conditions beyond anyone's control. In any event, there is a need to be more realistic in both evaluating opportunities and planning implementation.

*3. Employers need technical assistance; it is not clear that financial subsidies make a long-term difference.*

As described in the section on "Linking Providers and Employers," employers almost always need technical assistance, including training, in order to establish in-plant services. In single-company subprojects, USAID has supported such assistance. This was true even at Milpo Mining, which would not (and could not) have carried out the business analysis on its own and needed help to forge relationships with local NGOs. In some umbrella subprojects, as in various PCPD cycles and the PMAP program, USAID funded NGO technical assistance, at least initially. Without technical assistance, even the most willing company may not develop quality services. Since this is a major USAID concern, it is reasonable to continue to provide technical assistance through a variety of avenues.

Experience to date does not provide conclusive evidence that financial grants or subsidies make a difference in the long run. Surely more companies will agree to become partners if they have a financial incentive, even if they are required to make their own contribution as well. However, it is not clear that such a subsidy does much more than aid in the start-up of an in-plant service. Further, companies are not accustomed to direct donor subsidies; they are accustomed to more businesslike deals such as the PROFIT arrangements that involve little or no subsidy funding and significant joint venture or other financial commitments on the part of the company. This may well explain the relatively slow pace of partnering under that project. Until more time has elapsed and USAID can determine whether the subsidized programs really continue and/or stimulate replication, there is no way to judge the effectiveness of financial subsidies.

Grant-type financial subsidies that require an employer contribution have been called "risk sharing." While such terminology may be technically correct, it obscures the fact that the risks of the various parties are not comparable. The company is risking its own money up front and also presumably committing to provide long-term financial support to this activity over the wide variety of other possible activities. In the case of USAID, the money may be earmarked for FP, but there is no long-term risk or commitment outside the risk that the use of public money will not result in the desired outcome. For an implementing agency, the program may involve risking its reputation and competitive position. It is important for USAID to gauge the overall effectiveness of such subsidies against the risks involved when sufficient data are available.

*4. Commercial insurers and conservative managed care organizations usually require a financial subsidy as well as technical assistance to minimize their risk.*

Insurance companies need technical assistance to initiate new plans, provide new coverage, target new market segments, or directly provide new FP/MCH services. Assistance may involve plan design and marketing; access to and linkage with new service points; facility improvements; staff training in management, sales, or service delivery; management information systems; and more. Insurers may be persuaded to share these costs, but it is unlikely that USAID can avoid paying altogether.

Given that commercial insurers are basically conservative and risk-averse, donors may be required to cover any initial losses or provide other risk-protection arrangements, as is the case with AAR and

PhilamCare. Thus, a financial subsidy is likely to be required.<sup>6</sup> The imperative is to carefully and accurately assess the potential loss and, where possible, persuade the insurer to risk at least some portion of that loss.

*5. Simplified data requirements and better management systems are needed to more effectively collect and use project data.*

USAID funding carries significant data-collection and reporting requirements. Some of the data may have at best only a tangential relationship to the specific subproject's objectives and may instead reflect USAID's understandable desire for an information framework that unites diverse activities (see the section "About Evaluation" below). These requirements, even when directly tied to subproject objectives, are by and large burdensome for employers, partners, and NGOs. Moreover, they require installing systems and procedures to generate information USAID considers critical but which the collector may consider irrelevant and useless. For example, an employer is unlikely to be concerned about whether the user is new or continuing unless increasing contraceptive prevalence within the company population is a clear objective. As another example, a managed care organization initiating FP/MCH coverage for the first time may be interested in the number of users as a measure of cost, but may have no interest in CYP or the users' prior FP sources. Conversely, USAID may have no interest in the insurer's profits/losses from related services unless the subproject involves a loan repayment arrangement, whereas profitability is the partner's major concern. Further, USAID's legitimate interest in public cost per user or CYP is of no concern to private sector partners. Indeed, many are not even concerned with their own cost per acceptor, but rather with their return on investment.

In many subprojects, USAID funds have supported the installation of management information systems (MISs) to collect and generate the required data. They have also supported a considerable level of effort among project staff to monitor data collection, quality, and reporting. In cases where the data do not serve the partner's interest, these investments yield little in the long run, and the systems are likely to die as soon as subproject funding ends. From the standpoint of value and pragmatism, it may be better overall for USAID itself (through a designated agent) to collect any required data that the partner neither wants nor uses. With respect to those data in which both parties are interested, the imperative is to select the smallest possible number of indicators.

A related issue, financial reporting, is less easily resolved. Various U.S. laws and regulations put enormous accounting burdens on fund recipients, often requiring new systems, formats, classifications, documentation, etc. In essence, recipients often establish separate accounting arrangements, parallel to but different from their own, and considerable project staff time is devoted to financial monitoring. This phenomenon is not, of course, limited to employer-based FP/MCH programs. However, it is harder to convince a one-time corporate recipient to expend valuable funds on this function than it is in the case of an NGO that already knows the cost of doing business with a donor. USAID can do little about the regulations under which it operates, but perhaps fewer direct subsidies and more traditional (from the

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<sup>6</sup> With AAR, the subsidy takes the form of a loan at slightly below commercial rates. The loan to PhilamCare was a no interest loan and, because of the high risks, PhilamCare is not responsible for repayment of budgeted losses.

partners' point of view) business arrangements may maximize the funding available for programmatic experimentation.

## About Evaluation

Project-related literature shows a continuing search for common ground on which to evaluate the impact of USAID's employer-based programming and to determine the relative effectiveness (often variably defined) of various approaches. This is an admirable objective, but it is premature.

### FIGURE 8: ABOUT EVALUATION

1. Definitive, scientific impact evaluation of employer-based programs is not possible or cost-effective at this time.
2. Investment in long-term follow-up may be very beneficial in assessing program sustainability and replicability.

#### *1. Definitive, scientific impact evaluation of employer-based programs is not possible or cost-effective at this time.*

Subprojects can be evaluated according to whether they met their individual objectives—which by definition are relatively short-term. Some subprojects have several objectives with variable time frames. For example, each PROFIT activity has two sets of objectives, one under the financial area and the other under the FP rubric. Those activities with slower gestational periods and an early focus on financial aspects are not likely to make significant progress toward the service objectives. Thus, even when it is possible to aggregate achievements, the aggregation may not be meaningful because there is no common standard against which the data can reasonably be compared. Even within the seemingly similar group of companies in Zimbabwe, for example, where the implementation approach was fairly uniform and the objectives comparable, both baseline and results data are inconsistent (see Appendix A).

An Evaluation Project document (Knowles and Akin, 1995) states:

A major evaluation question for employment-based services is whether they have any net impact (i.e., after adjusting for substitution) on contraceptive prevalence and fertility....[E]ven where employment-based schemes have no net impact on contraceptive prevalence, they may affect contraceptive effectiveness and hence, fertility, if users switch to more effective methods. Similarly, increases in contraceptive prevalence may be observed, with no attendant decrease in fertility, if contraception is substituted for abortion.

The study goes on to point out some of the difficulties in evaluating these kinds of programs, both operational and theoretical, and discusses the pluses and minuses of prior impact indicators, suggesting the following four:

- # full cost per CYP (e.g., including both private and public costs) to measure efficiency
- # net CYP (gross CYPs minus the number that would have occurred anyway) to measure impact on contraceptive prevalence
- # net public cost (direct cost minus the public cost savings associated with transfer from public or other subsidized sources) as a measure of impact on financial sustainability
- # net public cost per CYP (requiring segregation of prior commercial sources users from public source users) as an indicator of cost-effectiveness.

Many of the subprojects described in this paper are not mature enough to generate these kinds of data. For example, in the more experimental managed care arrangements, there may be few CYPs to date, and full cost per CYP would be astronomical even if it could be calculated. In the older, more traditional subprojects, such as the direct subsidies to single employers or the NGO-provider linkage arrangements, enough time might have elapsed to make the calculations, but the data are not available. Further, the cost of collecting them would escalate subproject costs to an unacceptable level.

USAID must define its long-term impact indicators so that all partners can understand what these programs are supposed to achieve and, where feasible, can begin collecting the right data. However, it is highly questionable whether USAID should invest in attempting to determine how these experiments stack up against the indicators until strategies are at least well underway and at best proven from an operational standpoint. Instead, USAID likely will have to rely on subproject-specific achievement of objectives to best direct its funding.

*2. Investment in long-term follow-up may be very beneficial in assessing program sustainability and replicability.*

USAID is placing increasing emphasis on sustainability. In employer-based programming, sustainability means private companies (on their own or through managed care) paying for FP/MCH services over the long run. There has been an expectation that successful strategies or programs will be replicated, spontaneously or otherwise. Good faith end-of-project reports have made impressive claims of sustainability, but these are speculative. A few have also claimed replication. Outside of an Enterprise follow-up study (Fort, 1994) that provides very short-term post-project data on a small group of subprojects and a PCPD study (Cabignon, 1994) that documents the types of services maintained by the employer in various intervention cycles, there is nothing to evaluate the accuracy of these claims.

The first challenge is to define what a sustained program is (e.g., one that continues without subsidy for 5, 10, or 15 years, one that continues some but not all components for some number of years). Once this is clear, USAID can determine which activities meet the sustainability criteria. Companies (employers or insurers) are unlikely to be willing to share with USAID any data about their financial operations (e.g., return on investment, profit), but there is no reason for them to resist answering questions about whether certain activities continue. The investment required for follow-up can be kept to a reasonable level if the key questions are simple enough. Until these key questions are answered, there are really no hard data on which to judge the effectiveness of USAID's programs in establishing sustained employer-based services.

## 4. FUTURE DIRECTIONS

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USAID's leadership role in employer-based FP/MCH programming and the creativity of implementing organizations have resulted in a pool of experience with promise for the future. Many things have been proven: some employers, under selected conditions and for a variety of reasons, will accept and contribute to FP/MCH services in the work-place or purchase them through fee or managed care arrangements; some insurers will experiment with new markets and new products; and satisfactory provider-employer arrangements can be made. Further, it is clear that the world in which these programs work is not homogeneous, that a host of uncontrollable factors compete with structured interventions, and that long-term outcomes remain to be seen. Figure 9 outlines the factors that have been demonstrated to stimulate the initiation of employer-based services.

### **FIGURE 9: FACTORS STIMULATING INITIATION OF EMPLOYER-BASED SERVICES**

- C Stable economic environment
- C Commitment of top and middle management
- C Relative attractiveness of introducing FP/MCH services over other investment options
- C Good corporate financial health
- C Provision of social and/or health benefits and/or services, especially FP/MCH services
- C Intersection of employer and donor interests
- C Access to local technical support
- C Attractive rate of return
- C High proportion of women beneficiaries (workers or spouses)

Recent experience does not provide enough evidence to draw conclusions about which approaches work best overall or which approaches works best to achieve particular objectives, such as increasing contraceptive prevalence, averting births, reducing public cost, leveraging private funds, institutionalizing sustainable services within the private sector, improving the method mix, or reaching out to underserved populations. The past provides some information to estimate appropriate future directions, but the absence of post-intervention data leaves room for ambiguity.

All of this argues for continued flexibility and experimentation, with a clear understanding that no single indicator can define success. There is clearly also a need to invest in follow-up. Overall, however, the past does suggest some broad goals for future work in this area, including:

- # Broaden the area in which partners' and donors' objectives intersect.

- # Minimize direct financial subsidies in light of uncertain long-term results unless there is an overriding reason to do so, as in the case of reducing financial risks within the managed care arena.
- # Carefully identify partners' technical assistance needs and provide financial support to meet them.
- # Facilitate provider-employer networks through brokering linkages among employers, other for-profit organizations, NGOs, and health care or managed care providers, focusing on providers that require minimal technical or financial assistance.
- # Enlist the cooperation of umbrella business and professional organizations that have strong influence over member employers and can therefore stimulate participation among their members with relatively little support.
- # Disseminate and explore the effectiveness of self-help tools to help employers initiate delivery of FP and other health care services to employees.
- # Engage private sector partners in more business-like activities than simple cost sharing, which would help eliminate those partners who are unwilling to risk their own funds.
- # Improve partner choices, ensuring that the partner can carry out all responsibilities (e.g., start-up financing, quality service delivery, sales, outreach to new populations, etc.) by designing creative subprojects, providing technical assistance, and brokering appropriate linkages with supportive organizations.
- # Continue to integrate FP into other employer-provided health services, thus building on the existing infrastructures.
- # Set feasible and appropriate objectives given the duration of a project and refrain from making comparisons between projects based on incomparable measurements.
- # Gather only the data that is most appropriate and useful for managing and assessing a subproject.
- # Invest in long-term follow-up, particularly if the subproject is meant to be sustained (as opposed to being a pilot).

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## **APPENDIX A:**

### **DETAILED SUBPROJECT PROFILES**

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This appendix provides more detailed descriptions of employer-based subprojects outlined in Section 2. It also describes intervention results, where available. However, many of the activities are recent and/or still underway. Moreover, data are very inconsistent across activities and, in most cases, are limited to the project period. The sole exceptions are a small group of Enterprise employer-based activities described in a Service Expansion and Technical Support Project (SEATS) follow-up study (Fort, 1994) and selected follow-up data on a Philippine NGO industrial program (Cabignon, 1994). Enterprise ended in 1991. Data presented in the follow-up study reflect conditions in 1992-1993.

#### **A.2. Providing Direct Technical and Financial Subsidies to Individual Employers**

*Benguet Gold Operations (BGO), Baguio, Philippines, and Matling Industrial and Commercial Corporation (MICC), Mindanao, Philippines*

Both of these Enterprise subprojects provided initial financial and technical subsidies to improve and/or expand existing health services within the employment setting. Further, both employers were plantation-type companies with large, captive populations and a tangible prior commitment to providing a range of benefits and social services. Both were located in the Philippines, where the law requires employers of 200 or more workers to provide on-site family planning services. However, this law is largely ignored. Both companies were profitable at subproject start-up but began experiencing financial difficulties shortly thereafter.

BGO was fertile ground for a donor-supported intervention and required little marketing and persuasion. Consisting of five mine sites with over 5,000 employees and over 14,000 dependents, BGO had a long history of progressive management and extensive company benefits. In addition to housing and schools, BGO had a hospital clinic and had been offering family planning as part of its Community Health Services since 1970. BGO qualified for government contraceptives and other supplies. By 1986, the program was still operating but had deteriorated somewhat and was providing services only at the main clinic site. Enterprise provided support for a responsible parenthood program revitalization, including a cost-benefit study showing a 12:1 return on investment in FP services between 1971 and 1986, funding for physical improvements and training, computers, and other technical assistance. The assistance period was 1988-1989. A 1988 KAP study showed high levels of knowledge, a generally positive view of family planning, a fairly high level of contraceptive use, and a desire for more knowledge about the different methods. BGO shared costs, with BGO's actual expenditures exceeding its original commitment. While the goals of the Enterprise intervention refer only to FP, this program was implemented within the context of a company operation offering integrated FP/MCH and other health services, and the IEC component



extended beyond FP to include immunization, growth monitoring, and pre- and post-natal care. A secondary objective was to stimulate other Benguet Corporation components and other area mines to engage in similar programming.

Like BGO, MICC management was progressive. The company traditionally supported not only its 1,341 employees on the agricultural plantation but also the local community of approximately 40,000. It already had a plantation hospital providing limited FP, MCH, and nutrition services to employee families and local residents, but the facilities and equipment were inadequate. In addition to serving area residents at the hospital, MICC's social commitment extended to building and operating off-plantation schools and providing technical and material assistance to 6,000 local farmers. The 24-month intervention between 1987 and 1989 involved staff training in FP and upgrading facilities as well as developing outreach services by midwives-motivators and volunteers. The outreach component was later dropped due to security concerns in this very unstable region. Documenting and disseminating the company's experience was another objective. The subproject sought to enroll 1,200-1,500 users. MICC contributed about one-third of the funding.

### *Results*

End-of-project data show that BGO's program reached 82 percent of its new user target (1,256 out of 1,524) and 78 percent of its continuing user target (2,330 out of 3,006), with a continuation rate of approximately 60 percent. Subproject documentation defines the cost-benefit ratio of the FP program as over 7:1 and affirms an increase in contraceptive prevalence from 34.5 to 52 percent. BGO management remained convinced of the value of providing responsible parenthood services and vowed to continue to support them in their entirety. Also, plans were underway to expand coverage to sister companies within Benguet Consolidated Mines, Inc., in conjunction with a foundation that serves as the corporation's social development arm. BGO subsequently went out of business and presumably no longer provides FP/MCH services.

At the end of the MICC subproject, there were 770 new users (64 percent of the target), the facility was improved, staff were trained, and the program provided 402 CYPs. MICC management made presentations to other local employers, and another company was sending its employees and spouses to the MICC facility for FP services. There are no follow-up data on this program.

### *Company-Based Programs in Zimbabwe*

Beginning in 1987, Enterprise initially provided technical and financial support to four Zimbabwean employers. These include Lonrho Zimbabwe Ltd., Triangle Ltd., British American Tobacco (BAT), and the Commercial Farmers' Union (CFU) with a membership of about 4,550. Two CFU units, Doma and Nyanzura, participated. Hippo Valley Estates, located near Lonrho, was impressed with Lonrho's program and subsequently joined the other subprojects.<sup>7</sup>

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<sup>7</sup> Enterprise provided support simultaneously to the Private Sector Family Planning Unit within the Zimbabwe National Family Planning Council (ZNFFPC), a parastatal organization that coordinates all family planning activities for the government and receives the majority of its funding from the government.

The four companies had predominantly male workforces. The CFU sites employed both men and women. Both the companies and the CFU sites had on-site medical facilities. Subproject periods ranged from one year to about two-and-a-half years. All partners contributed to costs, with contributions ranging from 41 to 82 percent. Baseline CPR was 71 percent at BAT and 21.5 percent at Triangle. These data were not collected at Lonrho or CFU, which had baseline CYPs of 856 and 1,224, respectively.

Lonrho and Triangle were large employers (with work forces of 7,200 and 7,500, respectively) that already provided a range of social and health services to employees and dependents as well as to the surrounding communities. Lonrho already had a limited FP program. BAT, employing predominantly men, provided medical benefits to employees only and did not provide housing. Commercial farms in Zimbabwe did not provide any benefits except housing.

CBD subprojects were established at the two CFU sites. ZNFPC helped participating employers recruit, train, and deploy CBDs in the workplace and, if applicable, in the dependent community. At Triangle, Lonrho, and Hippo Valley, where on-site medical facilities existed and the target population included women, ZNFPC trained company nurses in clinical methods. ZNFPC provided SOMARC commodities. Enterprise also supported a cost-benefit study at Triangle and Lonrho showing the value of the investment, but the mid-term evaluation of Enterprise seriously questioned the analysis methodology.

A January 1996 PROFIT assessment of Zimbabwe's private medical sector revealed that more than 200 employers have on-site clinics, many of which provide some basic FP services and supplies, particularly condoms and orals. Medical aid societies, which are private, prepaid, nonprofit health insurance programs, generally provide some level of coverage for FP services and supplies, but members are not always aware of this benefit. There are 24 companies providing coverage for over 730,000 members and beneficiaries, constituting about 7 percent of the population. This coverage generally reimburses for FP commodities except for condoms, regardless of source.

PROFIT is currently formulating a strategy to increase employer involvement. PROFIT plans in-depth interviews with selected companies and an exploration of why programs do not include more methods and will then design a program strategy. PROFIT has not yet decided whether to focus on employers that provide insurance or on those that do not.

## *Results*

In a June 1990 report (Fort, 1990), Enterprise documented a number of achievements: at five Lonrho mines where baseline data were available, CYP increased by 145 percent in 21 months, and recorded births dropped by 28 percent and sexually transmitted diseases (STD) cases by 29 percent at seven mines; CPR nearly tripled at Triangle; CYP almost doubled in 18 months at the participating CFU farms; and at BAT, current and ever-use of condoms increased from 71 to 76 percent. At the end of these subprojects, all four original companies continued or expanded the provision of FP as an

employee benefit, and all were covering the entire costs of their programs, with the exception of CFU, which continued to receive donated contraceptives from ZNFPC.

The follow-up study provides a rather ambiguous longer-term picture. Despite recent serious financial difficulties, Triangle, Lonrho, and Hippo Valley Estates continued their FP services without external support, purchasing contraceptives from ZNFPC and Geddes, a commercial distributor. However, Triangle has laid off more than 5,000 of its 6,500 workers, and Hippo Valley has transferred most of its 4,300 workers to its other operations in Zimbabwe. Thus, it is unclear what services are continuing and who is using them. Of the CFU sites, Doma closed down its FP services shortly after Enterprise support ended, while Nyanzura continued and expanded its program to an additional 31 farms. CFU continued to receive subsidized contraceptives through ZNFPC.

*Mawana Sugar Works/Shriram Industrial Enterprises Limited (SIEL), Western Uttar Pradesh (UP), India*

SIEL Ltd. owns Mawana Sugar Works (MSW), a factory employing 1,600 people and interacting with 40,000-45,000 farmers who sell sugar cane to the factory. PROFIT's relationship with SIEL stems from its work with the Confederation of Indian Industry (CII). SIEL wanted to start a comprehensive MCH/RH program for its workers and to contract with Parivar Seva Sanstha (PSS), an experienced family planning NGO, for expertise on designing and implementing the program. PSS would survey needs, implement an IEC campaign, train health workers, and establish a contraceptive supply system. After the three-year contract period, SIEL would run the facility itself. In 1995, SIEL sought PROFIT support (\$26,700) for the PSS technical assistance. SIEL originally wanted to include the area farmers and beneficiaries, however, it was decided to exclude farmers initially, with this decision to be reconsidered after the first year of operation. PROFIT is funding a pre-implementation baseline survey and will fund the three-year program upon approval of the project design. No results data are available. If successful, it can serve as a model for replication throughout the UP sugar industry and elsewhere in India.

#### **A.4. Conducting Business Analyses to Attract Employer Participation**

##### *Milpo Mining Company, Peru*

With a workforce of 800 and with 4,000 dependents, Milpo is located in the interior highlands, where CPR is generally lower than the national average. In accordance with government regulations and collective bargaining agreements, Milpo provides family-related benefits, including housing. While workers' health services are covered by social security, Milpo maintains a hospital and outpatient clinic for families providing primarily curative services. The 1986 TIPPS analysis estimated that a FP program could more than double the CPR (from 34 to 75 percent), increase the effectiveness of the method mix, and reduce the number of births by 80 percent in the sixth year. A positive cash flow was projected for the fourth year and pay back of the initial investment for the sixth year. The net benefit-to-cost ratio would be 7.4:1 in the first five years, and the internal rate of return would exceed 50 percent. Because the baseline survey also demonstrated the need for child survival services, it was recommended that the company establish an integrated MCH and FP module. Milpo had been spending a considerable amount on drugs to treat preventable diseases, and this was a good opportunity for cost savings.

##### *Results*

Milpo decided to implement the integrated module in 1988 and bore all associated costs. These included hiring of an additional physician and nurse educator and contracting with two private institutions for training and on-site supervision. In addition, Milpo purchased contraceptives and laboratory services. The integrated services have become a permanent part of Milpo's benefits package. Within 18 months of implementation, CPR among miners' wives had risen by 41 percent, with the percentage of women using modern methods increasing from 16 to 40 percent. Vaccination coverage rose from 5 to 75 percent among children under age 5 in 20 months, and almost all children under age 1 were enrolled in growth monitoring. The incidence of diarrheal disease and acute respiratory infection (ARI) had declined, thus confirming the projection that Milpo's drug costs would fall. By the end of the TIPPS project, Milpo had marketed its program to area employers, and TIPPS reported that two other private mines initiated similar services, including contracting for medical staff training and supervision. Although the benefits package design did not include services beyond the Milpo family community, the physician performed vaccinations on his day off with the company paying expenses only.

Since the conclusion of TIPPS, the economic situation in Peru has declined, with hyperinflation seriously cutting into company profits. At least until about two years ago, Milpo was reportedly continuing to offer the integrated module, although it had reduced its staff somewhat. Also, it does not appear that the other mines, which made a good faith effort to start, have actually implemented programs.

*Electrolima Utility Company, Peru*

A similar analysis was conducted by TIPPS in 1986 for Electrolima, a parastatal company providing electricity for Lima and surrounding areas. Of over 3,500 employees, about 60 percent were classified as white collar (of which about 25 percent were women), and the remainder as manual laborers. The company provides benefits directly to the white collar employees, whereas manual laborers are covered by the social security system. Company health benefits include a variety of services, including free medical attention at the company clinic and by designated specialists, hospitalization and surgery, drugs and X-rays at the company clinic, dental treatment, laboratory tests, and blood transfusions. Women employees can take 90 days of paid maternity leave and eight months of lactation supplement. For dependents of both white collar and manual laborers, the company offers free general medical, pediatric, and dental care at the clinic. It also pays partial costs of emergency care, outside specialists, and hospitalization, and sells drugs at cost plus a small mark-up. Workers' wives receive pregnancy and postpartum care, with white collar wives eligible for more benefits. In addition to salary supplements, Electrolima provides social, recreational, and some education supplements but does not provide housing.

Fertility rates were relatively low, and abortion rates were relatively high. Contraceptive use (83 percent of women interviewed) was higher than the area average, and use of traditional methods was lower. The analysis projected little change in contraceptive prevalence, but a significant improvement in method mix. It also projected a benefit-to-cost ratio of 3.83:1 with a higher share of voluntary sterilization and 4.19:1 with a lower share. Similarly, it projected an internal rate of return of 127.08 at the higher rate and 140.04 at the lower rate. TIPPS recommended contracting out rather than integrating FP services into company facilities and projected a positive cash flow in year two and payback of start-up costs in year three.

*Results*

Despite the positive financial and health projections, as well as the board chairman's initial commitment, Electrolima declined to initiate FP services. Its benefits are financed by revenues. As a monopoly, it can raise rates at will to provide additional operating funds. Thus, there is no financial incentive to introduce FP/MCH services. Also, there was a change in board leadership, and negotiations with a service delivery NGO were problematic. However, the NGO did conduct IEC seminars for employees at Electrolima's expense.

**A.6. Linking Private Providers with Employers***Atma Jaya Hospital, Jakarta, Indonesia*

In 1982, Atma Jaya Hospital, a private institution, began providing FP services at small and medium-sized area businesses that could not afford the high start-up costs associated with providing these services. By 1986, the hospital was serving 20 factories with approximately 7,000 employees, including 2,677 eligible couples. This program was fully subsidized, and services to the employers were funded by a grant from Family Planning International Assistance (FPIA). Fourteen of the 20 factories paid fees to the hospital for some services, but not for FP.

In 1987, TIPPS assisted Atma Jaya in developing a hospital/factory service program for which employers could and would pay. The activity involved initial KAP and cost-benefit analyses at five factories, an assessment of the hospital's strengths and opportunities for improvement, determination of service delivery costs to facilitate pricing, the design of four service modules from which the employers could choose any combination (FP, outpatient services, prenatal and postpartum care, and medical check-ups), and marketing to the employers. Each module was individually priced. The FP service delivery options included factory-based clinics, factory-based cadres, mobile clinics, and the Atma Jaya Polyclinic. The subproject used BKKBN contraceptives. Socially marketed contraceptives, not available at the time, would have quadrupled the cost.

### *Results*

The marketing team made an average of eight visits before a corporate contract was signed, and the time period varied from four months to a year. Out of 88 area factories, 27 signed up for services during the two-year subproject period. Workforces ranged from 80 to 940. Of these, 17 signed up for FP, 14 for outpatient services, 4 for prenatal and postpartum services, and 7 for medical check-ups. Seven factories with in-house clinics that had not provided FP services before initiated these services during the subproject, with Atma Jaya staff providing training for the clinic midwife and paramedical staff, contraceptives, IEC materials, and backup services for clients requiring special care. Atma Jaya staff also selected and trained factory-based cadres for FP motivation among workers and assisted in monitoring and evaluation. Two of these clinics became totally independent, purchasing socially marketed contraceptives and receiving only backup services from Atma Jaya.

Outpatient services were the most profitable, and provision of medical check-ups was described at the end of the subproject as "...promis(ing) to be financially viable for the hospital." While FP services were also deemed cost-effective for the employer, the pricing calculation excluded overhead costs, shifting them to the health care services for which employers were more willing to pay, such as outpatient care. This suggests that, if all costs were included, the price of the FP service would not be sufficiently attractive. It also underlines lessons learned elsewhere with respect to the inherent unprofitability of FP services alone. Overall, Atma Jaya reached the break-even point in the first month of operations.

This program did shift users from public to private providers. Prior to the subproject, 44 percent of the employees were receiving FP services from public sources. This figure was reduced to 29 percent six months after subproject start-up. Available documentation indicates that these figures reflect transfers from public to private sources rather than dropouts.

### *Federacion Mexicana de Asociaciones Privada de Salud y Desarrollo Comunitario (FEMAP), Mexico*

FEMAP, in Juarez, is a national federation of 32 FP NGOs. Its leadership is well connected with industry leaders and has access to top management through social connections. Enterprise supported FEMAP in developing its capacity to sell FP services to industry. There were two subprojects with FEMAP, one to establish FP programs in 10 to 20 in-bond maquiladora companies in Ciudad Juarez (1989-1990), and the second to establish FP programs in nine General Electric (GE) factories in northern

Mexico (1989-1990). Women constitute two-thirds of the maquiladora workforce. GE was already contributing to the national social security program, which provides (for employees who have contributed at least 30 consecutive weeks prior to the benefit) at least three months paid maternity leave, nursing time for six months following childbirth, and time off for postnatal care visits at part or full pay.

It took FEMAP 18 months to convince GE to allow an analysis of possible savings from FP investment in two plants. While management had thought turnover was associated with workers leaving for other jobs, FEMAP found that the 144 percent annual turnover rate and the 7 percent monthly absenteeism rate were due largely to pregnancy and maternity leave. FEMAP repackaged its traditional FP services to be more attractive to the company. The package included occupational health and safety, X-ray, ultrasound, family medicine, and FP. There is no information on how the price was calculated or on the relationship between FEMAP's price and that of other potential providers.

### *Results*

By the end of Enterprise, GE had offered FEMAP a contract for services in two plants. The follow-up study revealed that these two contracts were still in effect, and that a third had been negotiated for another plant in Mexico City. User rates in the two original plants grew from a very small percentage of the female labor force (63 users) to 85 percent of married women of reproductive age (MWRA) by the end of the subproject.<sup>8</sup>

### *Philippine Center for Population and Development (PCPD)*

Formerly the Population Center Foundation, PCPD is a well-respected, longstanding NGO partner in the national responsible parenthood and/or maternal and child health (RP/MCH) program and a long-term beneficiary of USAID support. Since 1985, PCPD has been working in the industrial sector, helping establish in-plant RP/MCH programs. In three waves, it has refined its service package, its recruitment strategies, and its pricing schemes, although cost recovery has not been a major objective.

In the first wave of 30 companies, PCPD mobilized and trained in-plant volunteers, conducted monthly IEC activities, visited companies weekly, established a referral system, and conducted research and evaluation. In the second wave, supported by Enterprise, PCPD reached out to 21 additional companies and added six elements to the program. It provided equipment, required cost sharing, established and trained an in-plant RP/MCH team, oriented labor unions, oversaw an institutionalization workshop, and conducted cost-benefit analyses. In the third wave, PCPD engaged 60 more companies and added four more elements. These included a requirement that the company pay P10,000 (approximately \$400) for IEC, program orientation for top and middle managers, participatory planning and an inter-company workshop, and area coordination meetings of companies and governmental and nongovernmental agencies. PCPD's involvement with each company spans about three years, with the company slated to take over all responsibility thereafter.

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<sup>8</sup> Neither the follow-up study nor the 1990 report, entitled *Enterprise in Mexico: A Strategic Approach to Private Sector Family Planning*, offer any data on the number of companies engaged by FEMAP in the other subproject.

## *Results*

Results are mixed. PCPD was able to recruit additional companies in successive waves, but it became much more difficult, presumably because those companies already favorably disposed had joined the program. Enterprise reports show that PCPD had to approach 110 companies before enlisting the target 20, and some of them were smaller than specified in the original selection criteria requiring a workforce of at least 1,000.

With respect to independent institutionalization within the participating companies, the record is not entirely clear. Some of the companies have gone out of business or have been reorganized. The objective was for the companies to maintain four program components: service delivery, IEC, training, and in-plant volunteer mobilization. PCPD follow-up data show that of the 24 first-wave companies still in operation, only two were implementing all four components. The same is true for four of the 18 second-wave companies still in business. One first-wave company and three second-wave companies were sustaining service delivery, IEC, and volunteers. Six first-wave companies and four second-wave companies sustained the service delivery and volunteer components. Fifteen first-wave and seven second-wave companies sustained service delivery alone.

### *Jakarta Industrial Estate PuloGadung (JIEP), Indonesia, and Yayasan Kusuma Buana (YKB), Indonesia*

JIEP is a government-run industrial estate with an underutilized medical clinic on the premises. JIEP has 275 companies with a combined workforce of about 60,000. YKB is an NGO with experience in developing private FP clinics, many of which generate revenue. YKB also has marketed X-ray services to companies by its mobile van. An Enterprise-UNFPA study concluded that an HMO on the estate would be financially viable, and YKB was identified to run the HMO on a contract basis. However, JIEP was not seriously interested in this venture. A 1993 PROFIT survey revealed that companies were wary of joining an HMO, because the concept was relatively new in Indonesia and the government requires contributions to the national health scheme. Companies were interested in mobile preventive health service delivery, including annual physical exams and X-rays, and on-site counseling about disease prevention, work accidents and, to a lesser extent, family planning.

YKB then proposed to test market two packages of services:

- # a basic package of FP and preventive health services, including individual and group family counseling, a physical exam, and blood and urine tests
- # a supplemental package including contraceptive products and services, chest X-ray, and vaccinations.

PROFIT supported the market test. Cost recovery was designated as the principal indicator of success.

## *Results*



The test was completed. In addition, promotion materials were produced, training manuals on FP methods and counseling were developed, six doctors and two paramedics were trained, and the JIEP clinic was refurbished. Failure to implement suggested changes in clinic staffing prevented the subproject from moving forward.

## **A.8. Mainstreaming Family Planning and Maternal and Child Health Services into Managed Health Care Systems**

### *Feasibility Study for Sankalp Kiran, India*

Sankalp Kiran is an NGO service provider. Between 1989 and 1990, an Enterprise subproject assessed the feasibility of establishing an HMO to serve employees and dependents of 26 large and medium-sized companies in South Delhi. Findings showed that the venture was feasible if companies could be persuaded to switch from fee-for-service to a prepaid arrangement. Viability would depend on modest premiums, large volume (10,000 to 15,000 low- and middle-income clients), and cost control. Start-up capital was estimated at \$1.5 million, return on investment was not attractive, and the minimum break-even point was estimated at five years.

#### *Results*

The study was completed. For valid reasons, this idea did not attract any investors.

### *Commercial and Industrial Medical Aid Society (CIMAS), Zimbabwe*

CIMAS is Zimbabwe's largest medical insurance company and is a not-for-profit organization. The objective of a 1987 TIPPS analysis was to convince CIMAS to add FP to their benefits package. The insured population's CPR was already high (67 percent), and the total fertility rate was low (2.5). Most women (64 percent) were obtaining methods from ZNFPC. The introduction of CIMAS coverage was projected to shift users to private providers. The cost to CIMAS would be high, and the FP benefits low. TIPPS then persuaded ZNFPC to provide services to CIMAS beneficiaries exclusively at twice or three times the price charged to regular ZNFPC clients. Although no strict analysis was conducted, these prices were probably below ZNFPC's costs. CIMAS later allowed its enrollees to receive services from private providers but placed a cap on the amount reimbursed.

#### *Results*

FP coverage is a permanent benefit for CIMAS beneficiaries. There are no data on the costs to CIMAS. A 1991 TIPPS report stated that CIMAS contributed \$20,000 in the first year but did not list the TIPPS project contribution. CIMAS's agreement to extend coverage reflects several motivations. First, the government sets CIMAS's rates, and CIMAS was interested in gaining favor with the government to negotiate rate increases. Second, at the time of the analysis, CIMAS was trying to attract new enrollees from the lower-income, blue-collar market. FP might help market to this group and, because the group's contraceptive prevalence was lower, reduce costs for other CIMAS-funded

services. Finally, the executive director of CIMAS was in favor of the initiative, despite its costs. Today, nearly all of the private medical aid societies (MAS) in Zimbabwe have added FP to their benefits packages. As of the 1994 Demographic and Health Survey, 7 percent of FP services were provided by the MASs, while ZNFPC was providing 23 percent.

#### *Adding Family Planning to Health Insurance Coverage in Jamaica*

There are five health insurers in Jamaica. Four are for-profit and provide life insurance as well. The fifth, Blue Cross of Jamaica (BCJ), is a not-for-profit division of Group Hospitalization and Medical Services, Inc. (GHMSI) of Washington, D.C., and provides only health insurance. BCJ serves over 60 percent of the health insurance market. PROFIT first explored expanding BCJ's health care package to include FP. This would require upgrading BCJ's claims processing and management information system. BCJ agreed to include FP coverage in exchange for computer equipment. Under a joint venture, PROFIT would acquire and lease computer hardware, concentrate on market research and FP product development, and establish a coinsurance or reinsurance fund as a source of ongoing funding. GHMSI would fund software design and purchase as well as the upgrading of BCJ's senior management capabilities.

A second initiative was designed to include FP in the coverage of all five companies.<sup>9</sup> Targeting large employers, the concept was to add FP to prepaid coverage, with prepaid services delivered by the Jamaican FP Association facilities and mobile clinics. Insured participants would contribute a 20 percent co-payment. The remaining cost would be shared equally between the insurers and PROFIT, with PROFIT establishing a coinsurance/reinsurance fund to cover its half. The insurers agreed to participate only if their costs would be reduced through decreased medical claims. PROFIT's contribution would offset the cost to the companies of increased claims generated by the new coverage.

#### *Results*

GHMSI, apparently experiencing financial problems, did not provide the financial and managerial resources required for the BCJ program. With respect to the five-company proposal, an analysis showed that cost savings from fewer medical claims did not exceed the cost of implementing the program. Also, the largely white-collar, insured population was likely to already be paying for FP services, and the subproject would have little impact on the existing CPR of 55 percent. The reliance on the NGO provider offered no opportunities for cost and utilization control. The subproject did not move forward, as the investment was not justified, and there was little chance that the subproject would be sustained after PROFIT funding ended.

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<sup>9</sup> PROFIT felt after the BCJ initiative that there were no further opportunities to work with life insurance companies in Jamaica.

*UNIMED National Health System, Brazil*

Founded in 1967, UNIMED is a cooperative of Brazilian physicians which had 62,000 members in 1992. It is among the world's largest HMOs, with 8 million clients in 1992. UNIMED is managed by physicians and directly provides medical assistance, diagnostic services, and hospital care. There are 196 local cooperatives, each of which is a separate legal and financial entity. PROFIT entered into agreements with two of these entities to expand UNIMED coverage for FP, improve the method mix, and stimulate replication throughout the UNIMED system.<sup>10</sup>

One of the agreements was with UNIMED/Maceio, which is located in northeastern Brazil and covers 32,500 people in 1992, 40 percent under company plans. It was operating out of a rented building. Through a joint venture corporation, PROFIT and UNIMED negotiated to purchase, renovate, and run an existing hospital owned and operated by three physicians. PROFIT had a 49 percent interest. Central to the deal was UNIMED's agreement to establish an FP/MCH clinic at the hospital and to include FP in covered services. The subproject strategy also included marketing HMO services to employers whose employees were not enrolled in the UNIMED HMO and were less likely to have access to health care or FP services. PROFIT would also fund up to \$20,000 of technical assistance in FP/MCH clinic design and training, contributing to PROFIT's total \$1.1 million of investment and technical support. Prior to this arrangement, UNIMED physicians were providing FP/MCH services in their offices on a fee-for-service basis. A subsequent survey showed high contraceptive prevalence in the catchment area.

*Results*

This agreement has not worked out particularly well. The clinic opened in August 1995, but utilization has been low and has been focused more on pediatric than FP services. A local accounting firm is now doing a pre-buyout analysis for PROFIT's divestment.

*PhilamCare Health Systems, Inc., Philippines*

PhilamCare is the leading Philippine HMO. It is owned by its nine founding physicians (40 percent) and Philamlife (60 percent), a wholly owned subsidiary of the American Insurance Group. In 1992, it had 20 percent of the national HMO market and served 100,000 plan members, mostly group enrollees in three plans targeting the formal sector. A 1991 feasibility study of expanding managed care coverage to the informal sector was not particularly encouraging but suggested a trial test of the market. The informal sector is not covered by national health insurance.

With a follow-up feasibility study showing potential for such a program, the Low Cost Health Care Plan (LCHP) was begun as a demonstration subproject offering a relatively low-cost private sector health care option called HealthSaver to low-income Filipinos, with providers paid on a capitation basis in 1994. Unlike PhilamCare's other health plans, HealthSaver limits the enrollee to a single facility. The three facilities

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<sup>10</sup> PROFIT had approached a for-profit Brazilian HMO with its own hospitals. This HMO expressed interest in a joint venture and in setting up a family planning facility in Sao Paulo. However, PROFIT did not pursue this opportunity as USA preferred that PROFIT focus its efforts in northeastern Brazil.

chosen were one hospital in Manila and two in Cebu. Family planning is included in the package, but this objective is secondary to that of testing the low-cost capitation model. Under the terms of the agreement, PROFIT is essentially providing a no-interest loan to PhilamCare to cover initial plan losses. It is also providing technical assistance to the hospitals for FP service delivery. PhilamCare has assigned a dedicated sales force for HealthSaver.

### *Results*

This subproject has faced challenges associated with reaching the informal sector and identifying hospitals willing to accept capitation payments. These challenges delayed start-up for two years. The subproject is still very new, with target enrollments (9,000 in year one and 12,000 annually thereafter) behind schedule. Also, both losses and revenues are lower than expected.

The designated Manila hospital was extremely risk-averse and ultimately refused to participate. PhilamCare initially transferred these enrollees to its own clinics for outpatient services and paid fees to the hospital for inpatient services. PhilamCare has now enlisted another Manila hospital which provides both inpatient and outpatient services on a capitation basis. Of the two hospitals in Cebu, the one with the better reputation was resistant, and the one with the lesser reputation was not attractive to plan members. To replace the Cebu hospital that failed to participate, arrangements have been made with another hospital that is now providing all inpatient and outpatient care, including FP. Subsequently, PhilamCare contracted with two hospitals, one in Manila and one in Cebu, which are willing to work on a capitated basis and are committed to offering FP services.

### *AAR Health Services, Kenya*

AAR is a high-quality, well-organized insurance company offering prepaid coverage for health services to employers and individuals. It is the nation's only health insurer that operates its own outpatient facilities in Nairobi and Mombasa. These facilities do not provide FP services. PROFIT explored two collaborative initiatives with AAR, seeking to institutionalize FP services within AAR's program. In working with AAR, the primary goal was to shift the burden of service from the public to the private sector rather than to increase contraceptive prevalence. Although AAR's market is primarily high-end, the company expressed interest in establishing a managed care business to expand its market share by attracting lower income clients.

The first venture involved AAR marketing primary health services, including FP, to large employers in the Lake Naivasha region. Sulmac Company, Ltd., was targeted because it is the region's premier employer, because it already provides health services to employees and dependents at a company-owned clinic, and because it uses its health benefits as an incentive in recruiting the best workers in the area. Sulmac employees had benefitted from USAID-supported FP services for 10 years, and acceptance was high. Also, the government was asking Sulmac to offer services to others in the community, making the cost-containment features of an HMO concept potentially attractive. Another factor was that Sulmac's clinic-related costs were escalating, and the company was considering having someone else manage it. The proposal was that Sulmac purchase a pre-paid health care service package for its employees and that AAR lease and upgrade the current health facility so that it could offer managed care services to non-employee

workers in the region. PROFIT would offer a six-year loan of \$520,000 to AAR to facilitate AAR's investment in the facilities (with the first tier slightly below commercial interest rates) and would provide technical assistance in developing a managed care business plan and an acquisition proposal to Sulmac. The loan would be secured by the clinic facilities, and PROFIT would assume the currency risk.

The second venture involved AAR establishing a primary care clinic in the Nairobi industrial area, with three outreach clinics in the main residential areas, and selling a prepaid package of services to area companies. The package provides for integrated services, including FP. The potential target population was over 20,000 workers and dependents, and the industrial area currently has no FP services available through employers for these workers and dependents. This approach was deemed more cost-effective for PROFIT than marketing directly to area companies. Under the terms of the agreement, PROFIT is making a six-year loan of \$414,000 to AAR at a 13 percent interest rate (slightly below commercial rates) and providing an additional \$25,000 for technical assistance in FP and managed care training. PROFIT is assuming the currency risk. PROFIT is also collaborating with Management Sciences for Health to provide managed care training and with the Access to Voluntary and Safe Contraception International (AVSC) and FPPS to provide FP training. The agreement requires AAR to provide FP at these facilities. There was no baseline KAP-type assessment, but there was a survey to determine where to locate the clinic sites.

### *Results*

AAR was interested in the Sulmac venture, but Sulmac declined to participate for several reasons. This experience shows the many complex factors that enter into a company's decision about providing benefits and/or innovating in service arrangements. First, Sulmac had been looking to reduce the costs associated with the clinic, and contracting out the clinic showed little cost savings in the short term. Second, Sulmac was concerned about the potentially negative effect of contracting out on its image as an employer; it feared the company may appear to be taking a less active role in providing health care for employees, which would reduce its competitive edge in personnel recruitment and have a negative effect on labor relations as a result of harder-line benefit decisions by AAR.

The Nairobi Industrial Area subproject is being implemented with the opening of the medical center in September 1995. AAR has begun marketing to area companies. The goal is to increase total membership from 9,600 as of July 31, 1995, to 13,300 by April 30, 1996. AAR is having difficulty locating sites for outreach clinics in the residential areas, causing some delay in establishing these clinics. The main clinic is certified by the government and therefore is eligible to receive free contraceptives. AAR is sharing all technical assistance costs equally with PROFIT.

## **A.10. Working through Umbrella Business and Professional Associations**

These initiatives attempt to capitalize on economies of scale as well as to facilitate access to employers and engage them in in-plant service delivery.

*Personnel Management Association of the Philippines (PMAP), Cebu Chapter*

Cebu is the industrial hub of the central Philippines. At the time this activity started, there were about 110,000 workers at over 17,000 companies, 130 of which have over 200 workers. A baseline study at five companies showed an average CPR of 32.2 percent, with almost half of the users reporting using a traditional method. The PMAP Cebu chapter has 70 members. As PMAP's first major project-type undertaking, from 1988 to 1990, Enterprise supported a rather complex arrangement that involved other organizations and subsidies. PMAP members were responsible for persuading their own company management to introduce in-plant FP. Following the signing of a Memorandum of Agreement between the company and PMAP, the Cebu Chapter of the Family Planning Association of the Philippines (FPOP) trained clinic staff as necessary and delivered motivational lectures. FPOP provided supplies to in-plant distributors who then sold them on a commission and returned the balance to FPOP. FPOP projected recovering 10 percent of its project staff costs in year one and 40 percent in year two. PCPD, under subcontract to PMAP, developed and produced IEC materials and conducted special training for PMAP and the Department of Labor and Employment (DOLE). A university was slated to conduct baseline studies and an overall evaluation, but PMAP ultimately took on this responsibility. Targets included 30 companies with a total labor force of about 16,000 and enrollment of half of the eligible MWRA workers or spouses, or 3,080 individuals, as users.

*Results*

PMAP encountered company recruitment difficulties for a variety of reasons. More than one year into the subproject, 18 had been recruited, with several of these deferring program initiation until later. PMAP also enrolled a barangay (municipal unit), which is home to about 5,000 cottage workers, and the Atlas 4-H Clubs. Together, these 20 organizations had an eligible population of 13,011. Because enrollment was slow, cost recovery objectives were not met. The follow-up study states that 30 companies eventually enrolled, but seven were lost to government distributors providing free contraceptives. Also, nine companies went bankrupt.

*Indian Chamber of Commerce (ICC), Calcutta*

Between 1988 and 1990, this subproject combined the umbrella organization approach with the provider-employer linkage approach. ICC identified companies to receive assistance in establishing employer-based FP programs, and Sankalp Kiran was slated to provide technical assistance. ICC had little or no continuing involvement. No in-plant motivators were trained, and all services including temporary methods distribution were provided off-site. Limited IEC materials were available, and management involvement was minimal.

*Results*

ICC initially identified four companies interested in participating. Two dropped out early. After the end of Enterprise support, a third halted services, though this company later hired Sankalp Kiran to provide services at two other plants outside Calcutta. At the fourth company, Sankalp Kiran continued to

provide services, but management refused to contribute. Sankalp Kiran covered the costs with other donated funds.

### *All Indian Organization of Employers (AIOE)*

Between 1988 and 1990, this subproject worked through AIOE headquarters in New Delhi to stimulate program implementation by three local employer federations in Bihar, Karnataka, and Rajasthan. These three areas were underserved. The goal was to establish in-plant FP programs in up to 60 industries and in the informal sector among bidi cigarette makers and tile workers. The target was 30,000 workers in each area. The motivators distributed pills and condoms to coworkers and in the community. Subproject officers and motivators referred users to public and private area facilities for other methods, such as IUD and sterilization, and for counseling.

### *Results*

With a variety of Enterprise technical assistance and financial support and contributions from AIOE and local host organizations, the subproject trained 240 in-plant motivators, enlisted about 20 companies in two of the areas, and reached a total of less than 7,000 users. However, within about six months after Enterprise funding ended, nearly all programs had ceased operation.

### *Confederation of Indian Industry (CII)*

In response to USAID's interest in disseminating information on employer-based FP as well as to corporate inquiries directed to CII, PROFIT supported the development of a users' manual showing companies how to become involved in FP programs. This manual was to be launched at a seminar in the summer of 1996. PROFIT will distribute a questionnaire eliciting opinions about the manual and information about users' plans. It may also conduct a six-month follow-up study to see if companies follow through on these plans.